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CONTENTS AND SUBJECT INDEX

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. . . TO MEN OF GOOD WILL

That all men everywhere may breathe again as free men ☆ ☆ That suffering and oppression may vanish forever from the earth ☆ ☆ That all men may regain their self-respect ☆ ☆ That the labor of all men may be devoted to the good of mankind ☆ ☆ That the pain and the hurt of all men be mercifully healed ☆ ☆ That all may live in peace forever!

We, men and women of Wyeth . . . as one voice, make this wish. To the doctors and nurses in our Army and Navy in the far corners of the earth; to our doctors and nurses at home; to our druggists; we at Wyeth are proud to have been of service. Proud and honored to have received our third Army-Navy "E". To you, men and women of mercy—our hand and our utmost support at all times.

Wyeth

CALIFORNIA AND WESTERN MEDICINE

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EDITOR . . . . . GEORGE H. KRESS

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

SEASON'S GREETINGS: TO MEMBERS IN MILITARY SERVICE AND IN CIVILIAN PRACTICE

First, Greetings to members of the California Medical Association who are in military service. To each of you, Season's Greetings from your colleagues who are holding the fort in civilian practice. Those of us who remain at home, wish you who are a part of the Armed Forces to know we are mindful of the sacrifices you have made, and are making, and are proud of your achievements and the splendid manner in which you are exemplifying the ideals of the medical profession, and we pledge you our troth that we shall keep in mind our obligations to safeguard your interests.

In similar spirit, CALIFORNIA AND WESTERN MEDICINE extends to C.M.A. members who are carrying on in the home front, All Good Wishes, and expresses the hope that increased burdens in civil practice will only add to your strength and determination to do all that is humanly possible to permit us to give to all the people of California, the highest quality of medical srevice, in line with the best traditions of the healing guild.

Insofar as the welfare of the medical profession and the public health are concerned, the coming year, and years to follow, will be of vital importance. Let each of us agree to be alert to impending changes, and determined to battle firmly for principles and measures that will not only redound to the best interests of California's citizens, but also make for the maintenance of procedures in medical practice that will permit Doctors of Medicine to carry on their work with greatest good to all.

AMERICAN PUBLIC HEALTH ASSOCIATION: ITS RECENT HASTY ACTION GIVING APPROVAL TO GOVERNMENTAL MEDICINE

How a Minority Group can Commit a National Organization to Policies on Important Issues.—On October 4, in New York, at the annual meeting of the American Public Health Association, its administrative body, the "Governing Council," as represented by 63 out of some 100 eligible members who have power to vote, adopted a resolution by a ballot of 49 in favor of, to 14 against, approving resolutions that are in essence an endorsement of federal legislation that

would bring into being compulsory health insurance for the United States.

The story of what took place was well covered in editorial and other comment in the *Journal of the American Medical Association* for October 14th, on pages 434 and 441, and is worthy of perusal by physicians who wish to keep themselves informed concerning current trends that may lead to the establishing of a system of political medicine designed to take the place of scientific medical practice as it has been developed in the United States.

* * *

Reason of Present Comment.—The action taken on behalf of the American Public Health Association receives comment here, not only to call the attention of C.M.A. members thereto, but in order to clear the record of the Director of the California State Board of Public Health, Wilton L. Halverson, M.D., chairman of the American Health Association's Committee on Administrative Practice; who, however, owing to illness. was unable to attend the meeting in New York. The resolution had been referred to Dr. Halverson's committee. Other Californians who were present, and colleagues such as Doctors Haven Emerson of New York, Walter L. Bierring of Iowa and others, were successful in securing postponement of action on the first day of the meeting, by moving to have this agenda item come up for consideration two days later. As a fact, the efforts they made in the meantime, through informal conferences and discussion, failed to prevent the action finally taken; which as stated, resulted in a vote by some 49 Councilor-Fellows in favor of what is practically a political medicine plan, as against some 14 ballots by Councilors who opposed the proposals. Another motion to postpone action and so permit joint consultation with the authorities of the American Medical and American Dental Associations also resulted in failure.

* * *

Significant Complexion of the Governing Council of the American Public Health Association.—The *J.A.M.A.* editorial rightly called attention to the make-up and complexion of the personnel constituting what is known as the "Governing Council of the American Public Health Association." It may be added further, that the membership of the said body is not composed of a majority of physicians. It has been stated to consist, to about 50 per cent, of lay teachers, sociologists and other persons of similar connections; the remaining one-half of the Governing Council consisting of Doctors of Medicine, of whom, perhaps, one-half or more are not physicians in private or general practice, but full time or other public health officials. Consequently, the Governing Council of the American Public Health Association, insofar as a majority of its members is concerned, at the present time may be said to have only limited affiliations with private medical practice, as it is carried on by the great majority of physicians, a group whose members are, certainly, an intimate and important part of the public health background of the United States.

* * *

How Existing System of Medical Practice May be Menaced.—In calling attention to the above, the purpose is to direct the thoughts of practicing physicians to the menace that can arise to existing procedures in medical practice when, in organizations of national scope possessing great publicity potentialities (the American Public Health Association is one of such), the determination of the policies of such organizations, through infiltration or other tactics, is taken from practicing physicians; thus to become the medium through which lay enthusiasts, theorists and similar groups or individuals may carry on to better advantage an educational propaganda in the promotion of objectives to which they are mutually devoted.

* * *

Physicians, Because of Their Indifference, Must Blame Themselves for Some of the Sad Results.—If the action recently taken by the American Public Health Association is examined and clearly thought through, practicing physicians must acknowledge that they themselves need bear a considerable part of the blame for some of the situations that have come into existence.

Years ago should have been visualized, the desirability and need of bringing into close or closer relationship with organized and scientific medicine, those colleagues who were embarking on part or full time careers in public health. This could have been done through establishing of public health sections in our national and state medical associations. Instead, these public health colleagues were looked upon somewhat askance, as if they were not an integral and very intimate part of the medical profession. So that, having no other place of affiliation, they joined other professional groups, or established independent societies. This too, in spite of the fact that public health practice is not only a medical specialty in itself, but is an expression of medical practice that probably possesses greater public relation possibilities than any other specialty group in medicine or surgery.

Such conduct by the medical profession was in great error. One of the ill effects can be noted in the recent action taken by the American Public Health Association.

* * *

C.M.A. Recently Authorized a Section on Public Health.—California, at this year's annual session, took steps to rectify this mistake in procedure. At the recent May meeting in Los Angeles, the newly created Public Health Section of the C.M.A. not only got off to a good start, but on short notice had one of the best programs and largest attendance records of any of the Scientific Sections. Heretofore, in California, the public health officers who have affiliated themselves in the new Section had been obliged to hold their

meetings as one of the groups of public officials in the "League of California Cities," or through sessions of lesser attendance, as expressed in the Northern and Southern California Health Officer Associations.

* * *

Actions of the American Public Health Association May Result in Good.—If the recent action taken by the Governing Council of the American Public Health Association will bring home, to the national and constituent state medical associations a realization of the implications involved, when an organization representing a vitally important group of physicians in public health practice is permitted to be infiltrated and practically controlled by outside lay groups, the bitter understanding of what took place may lead to better orientation of the principles and issues at stake, and thus make for decisions to bring such set-ups and proceedings to an end. In other words, the medical profession must move in, and again take possession of its own. If not, then Doctors of Medicine will have only themselves to blame, and must be reconciled to accept the consequences of their own ineptness and inaction.

EDWARD M. PALLETTE

End of a Notable Career.—In the southern section of California, over a long period of years, few members of the profession have exercised greater influence than the late Doctor Edward M. Pallette, whose death occurred in Chicago, on November 16th. An obituary appears in the current issue of CALIFORNIA AND WESTERN MEDICINE, on page 317.

Doctor Pallette, an ex-president of the Los Angeles County and California Medical Associations had gone to Chicago to attend a meeting of the Trustees of the American Medical Association to which body he was elected in 1942. He attended meetings of the Trustees on Wednesday, November 15th, but during the night, presumably suffering distress, he had arisen to sit and read, and in the chair in his room at the Palmer House, he was found dead, on the morning of Thursday, November 16th.

Of Doctor Pallette it may be said that in the many professional and civic positions he held, and in his work as physician and surgeon, he always gave of himself in generous, conscientious and efficient service.

Since the beginning of World War II, it was his responsibility to act as the chairman of Procurement and Assignment Service for the southern section of California. In the absence of his son, Lt. Col. Edward C. Pallette (M.C.), Army Air Corps (who had been his office associate), he was at the same time carrying on a large medical practice. The arduous work required in the Procurement and Assignment Service was an additional, and responsible load which, however, in spite of its heavy demands on his strength and health, he willingly accepted as a duty to our Country. His passing takes from the ranks of the medical profession a colleague whose wise counsels will be sorely missed.

C.P.S.: ON PROCEDURES REGARDING CHANGES

California Physicians' Service Now in Its Sixth Year of Service.—California Physicians' Service, the statewide medical service plan inaugurated by and an integral part of the California Medical Association, from the time of its organization some six years ago, has been given a considerable amount of space in CALIFORNIA AND WESTERN MEDICINE. As one of C.M.A.'s major activities, an effort has been made in the OFFICIAL JOURNAL to keep members of the California Medical Association fully acquainted through minutes of the House of Delegates and Council, and through progress and other reports, with the organization and other developments of California Physicians' Service.

* * *

C.M.A. House of Delegates as Administrative Members of C.P.S.—Certainly, when at the annual session held in May of the present year, the House of Delegates recessed, then to be called to order, not as the House of Delegates but as Administrative Members of California Physicians' Service, to hear reports, discussions, and elect trustees of C.P.S., it once again, became plainly evident, that California Medical Association was determined to accept full responsibility for California Physicians' Service, be that for better or for worse. In making the important change in administrative procedure, it was hoped the component county medical societies would appreciate their more direct responsibilities to C.P.S., and their right and obligation to instruct their delegates to express at meetings of the House of Delegates and through communications to the Council, their respective reactions and wishes concerning C.P.S. policies and procedures.

* * *

Basic Changes in Procedure Need Study and Must be Legally Sound.—As has been repeatedly stated in CALIFORNIA AND WESTERN MEDICINE, California Physicians' Service was obliged to find its paths of procedure through the hard way,—by trial and error,—since there were no actuarial backgrounds for a service organization of such statewide scope. Officers of California Physicians' Service and members of California Medical Association alike agree that errors have been made. On the other hand, it should be remembered efforts have been constantly exerted to correct mistakes, and as promptly as possible.

A corporation, however,—and C.P.S. is a nonprofit corporation—must act in harmony with the corporate laws of the State and the enabling legislation that applies to a nonprofit medical service corporation. Changes in basic policies and procedures cannot be made over-night nor with undue haste. Since California Medical Association holds an annual meeting, with members of its

House of Delegates acting each year as Administrative Members, it was hoped it would be possible at such sessions to submit for full consideration and action and in regular order, resolutions on proposed changes in organization.

* * *

Letter of Alameda Members and Reply Should be Read by all C.M.A. Members.—In this issue of CALIFORNIA AND WESTERN MEDICINE appears a letter submitted by 21 members of the Alameda County Medical Association, they having made request for its publication in the OFFICIAL JOURNAL. The letter appears on page 302.

In connection therewith also appears the reply of the C.M.A. Executive Committee. The C.M.A. Committee expresses the hope that members of the California Medical Association will take the time to read the communications. They are important. Through perusal and thoughtful consideration by members of the component county societies, clearer understanding of the issues involved in proposed changes will be secured, and the best interests of all concerned will be better conserved.

EDITORIAL COMMENT†

PARADOXICAL RESISTANCE TO TUBERCULOSIS

In the course of a 10 year study of hereditary resistance to tuberculosis Lurie[1] of the Henry Phipps Institute, University of Pennsylvania, noted a marked discrepancy between the rapidity with which certain inbred rabbits acquired airborne tuberculosis and the severity and duration of the resulting disease.

Three rabbit families were tested. One family had a high hereditary resistance and two families a low resistance to injected tubercle bacilli. Injected intracutaneously with 0.2 mg. of highly virulent bovine bacilli, members of the first family survived for an average period of 539 days. The same dose killed members of two susceptible families in an average of from 121 to 141 days. In the resistant family the injection produced a slowly progressive tuberculosis with a tendency to localization, while in the two susceptible families the disease was always of a fulminating rapidly disseminating type.

Animals of all three families were subjected to parallel exposure to airborne tuberculosis, the source of the contagion being a neighboring group of rabbits inoculated intravenously with highly virulent bovine type tubercle bacilli. These rabbits were constantly shedding tubercle bacilli in their urine. Every 2 to 4 weeks the exposed rabbits were tested for acquired skin sensitivity, the onset of airborne tuberculosis being dated from the time the tuberculin reaction became definitely positive.

In a typical experiment all but one of the 8 resistant strain rabbits acquired tuberculin sensitivity in from 0.9 to 3.6 months, an average pre-allergic period of 2 months. In the two susceptible rabbit strains the pre-allergic period was over twice as long, averaging 4.7 months. Thus the susceptible rabbits were more resistant to airborne tuberculosis than the resistant controls. However, the severity of the resulting disease showed a different picture. The duration of the ensuing fatal tuberculosis ranged from 4.1 to 10.4 months (average 6.4 months) in the resistant family, as contrasted with an average duration of but 3.5 months in the two susceptible families.

From numerous data of this type Lurie concludes that rabbits of high hereditary resistance to injected tubercle bacilli have less efficient portal defenses to airborne tuberbulosis than more susceptible controls, while their internal tissue defenses are more efficient. There is thus a seeming paradox in hereditary resistance to tuberculosis, portal and internal defenses varying inversely with each other. This is a belated confirmation of an early epidemiologic theory, which assumed that there is no necessary parallelism between "Anfälligkeit" or disposition to an attack by a noxious agent, and "Hinfälligkeit" or tendency to succumb to the resulting morbid process. No adequate theory to account for this lack of parallelism has thus far been suggested.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Lurie, Max B.: J. Exp. Med., 79:573 (June), 1944.

†This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

CIVILIAN WARTIME PROBLEMS IN NUTRITION, FROM THE STANDPOINT OF THE PHYSICIAN*

A SYMPOSIUM†

LT. COMDR. DWIGHT L. WILBUR, MC-V(S)-U.S.N.R.
San Francisco

Introduction.—Doctors have not paid much attention to nutrition. In recent years the discovery of vitamins and, subsequently, the mass production of them, have forced upon physicians an awareness of this neglected field of medicine. Doctors usually have had less interest in health than in disease, because the "normal" is usually less stimulating than the "abnormal." In fact, nutritional-deficiency diseases have provoked greater interest among physicians than has any phase of normal nutrition.

If the medical profession is to continue to maintain its high place of leadership in society it must accept full responsibility for guiding society in the firm path of health rather than in keeping it out of the slough of disease. *Good nutrition* and *good health* are inseparable. A successful doctor should be an expert in both of them.

There is much more to the problem of optimal nutrition for all people than simple application of the principles of scientific nutrition. Problems of an agricultural and economic nature, to say nothing of that of food habits, are equally important with nutrition in attainment of "buoyant health" for everyone. Consequently, the physician must associate himself with all sorts of experts to meet satisfactorily the challenge of the great world problem of Food in either war or peace. Proof of the importance of this problem is well illustrated by the fact that the *first* United Nations Conference, with over forty nations represented, met in 1943 to discuss Food.

In an effort to bring a few of the more practical phases of this broad problem to the attention of physicians this symposium has been prepared. In it are represented a background of the importance of Food in wartime, and discussions of certain national and local problems in nutrition, of a normal diet, and of how to attain an adequate diet with rationing of food. From the clinical standpoint, physicians will be interested in discussions of the relations of vitamins to health and disease, of the great need for, and contribution of school lunches to health, and a listing of some of the useful and practical source-material in food and nutrition.

If the symposium is helpful in the solution or other problems, or if it stimulates interest in nutrition, the essayists will have been well repaid for their efforts.

† *Explanatory Note.* Concerning Four Symposia to appear in issues of October, November, December and January.

In every war there is a tendency to neglect the health, the safety, and the nutrition of those who are behind the lines. Famine and pestilence are facts of war and can be crucial factors in victory or defeat. Our present war is so large and is lasting so long that we will need to be especially alert well beyond the cessation of hostilities.

With the desire to promote optimal health in our civilian population four symposia have been compiled. These have been gathered as follows: (1) Symposium on Disaster Relief, by Henry Gibbons, III of San Francisco, appeared in October issue; (2) Symposium on Communicable Diseases, by Edward B. Shaw of San Francisco, appeared in November number; (3) Symposium on Nutritional Problems, by Dwight L. Wilbur, of San Francisco appears in current issue; (4) Symposium on Industrial Medicine, by Rutherford T. Johnstone, of Los Angeles, will appear in January issue.

* Foreword to a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

THE IMPORTANCE OF FOOD IN WARTIME*

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THE old saying, that the "Army travels on its stomach," applies with equal force to the civilian population in wartime. For, in modern war, the home front is as important as the battle front. The whole nation fights. Nearly every adult man and woman carries heavier burdens for longer hours at greater speed and this is a tax on body reserves, and calls for more calories and "building stones." But the irony of fate decrees,—perhaps as a reminder (to those who think) of the folly and waste of war,—that this increased need for more and better foods almost always parallels decreased food production, increased food destruction, and increased food waste by spoilage, so that all-out wars, global wars, invariably bring on malnutrition of varying kinds and degrees.

The drafting of ten million men into our Armed Forces, and the parallel increased needs of man power in the war industries interferes with food production on our farms, despite all care to the contrary. Some foods for our overseas forces have been sunk in transit, lost through enemy action on land, and spoiled in too long storage or by hot and humid climates. In countries where the actual battle fronts are located, there are more direct and extensive disruption of food production on the farms, and more direct destruction of food at hand. In addition, under conditions of modern naval warfare, excess foods produced in countries not at war (for example, Argentina) cannot be readily shipped to countries which have food shortage. In brief: war, calling for more than the peacetime calories for perhaps 75 per cent of the adult male population, creates at the same time conditions leading to decreased food production, increased food destruction, and increased food waste. Hence, food has become a mighty war weapon, food may well be the primary factor in victory as well as in defeat.

SOME RESULTS OF FOOD SHORTAGE

When food shortage or food scarcity actually hits a population, all people are not equally affected by this calamity, despite every effort toward rationing and relatively equitable distribution of the foods available. This certainly was the experience in Europe in World War I. The actual food producers, the farmers, will usually be the best fed. There is apparently no way in keeping account of, or securing the various foods on the farms produced in excess of the ration allowed for the farm families. If it comes to a pinch in our own country in the present war, I feel sure our experience will be the same. When foods are actually off the farm—

* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Department of Physiology of the University of Chicago.

in transit, in storage, or on sale in the cities—control and equitable rationing can be made more effective and just. But here comes the problem of "Black Markets," which spring up under these conditions in every land, created by those who have little conscience, but plenty of cash, to bribe farmers or middle men in the food industries with prices way above the official ceilings. Hence, the people in the cities with sufficient cash may secure foods in quality and quantity as abundant or more abundant than that of the people on the farm. The people hardest hit by food scarcity in war are obviously the people in the cities, in industries and professions who have not the cash to compete for food in the black markets. That means particularly, the large group of people in the lower income groups. Even without serious food scarcity and the mere beginnings of black markets, as is the case in our country today (because of the rise in food prices, particularly of the better or more preferable foods), the large group of our fellow-citizens who do not share in our wartime pseudo-prosperity, that is, the wartime increase in wages, salaries, and profits will suffer the most. These people find it difficult to secure adequate foods on their relatively decreased income, even though foods are available did they have the price and ration points to buy it in adequate quantities. Relative poverty is a factor that may increase wartime malnutrition, because of high and continually increasing costs of food, even if we should be able to produce and distribute foods as adequately as we have succeeded in doing to date.

In our own country and in Europe, the foods of highest nutritional value to man, such as milk, eggs, meat, fish, and poultry are usually also the most expensive. It was true in Europe in World War I, and has already been indicated in our own country in this war, these highly desirable, highly nutritious but expensive foods being the first rationed, the first to enter black markets, and generally the first to decrease in amounts available so as to upset the average usual dietary of the people in times of peace. As regards our own country in this war, the present scarcity of butter and meat is probably not so much due to scarcity of animal feeds and shortage of man power on the farm as to difficulties with distribution and the increased drain of these foods to our overseas forces and to lend-lease. But it is clear that direct destruction of food and disturbance of normal agricultural processes may reach a point where cattle, hogs, sheep, and chickens compete with man for grain and legumes as food. When that point is reached, it is obvious that cattle, hogs, sheep, and chickens must be sacrificed and all available grain used directly as food for man, since, when grains are fed to domestic animals used for meat, milk, or egg production, we get back in the form of animal food products, on the whole, less than 20 per cent of the food value in the grain so used. Under such conditions, milk, eggs, butter, and meat will practically disappear from the dietary, and man will have to fall back on grain, potatoes, legumes, fruits, and vegetables. I am reliably informed that in Norway 50 per cent of the cattle and 80 per cent of the poultry have been consumed as food in order to render more grain available for human consumption. Our own millions of pet dogs and pet cats compete with man for the superior foods of meats and milk. These dogs and cats are essential neither for victory nor for National existence, especially when men, women, and little children are starving to death in other lands. The American housewife and the American palate will have considerable difficulty, on the whole, to adjust to a dietary nearly or totally devoid of milk, milk products, and meats, even though it is well established that, providing a sufficient variety and quantity of grains, legumes, fruits, and vegetables are consumed by man, these are quite able to sustain growth in the young, and health and vigor in the adult human being.

CONFERENCE ON NUTRITION FOR NATIONAL DEFENSE

We were necessarily perturbed two years ago when, at the Conference on Nutrition for National Defense in Washington, D. C., men in responsible positions of our Federal Government announced that one-third of the American people suffered from malnutrition, and only about 23 per cent of our people could be said to enjoy a good diet, that is, a diet capable of maintaining good health. If this was the condition of diet and health in our country in times of peace and abundance of foods, what must it be under conditions of war when food scarcity of various kinds are almost sure to develop, particularly for lower-income groups in our population.[1] It should be pointed out, and it is a great comfort to know, that the medical examination of our draftees in this war did not indicate such a tragic state of diet and health in our nation. In fact, our draftees in this war are a little taller than the American draftees in World War I, and both of these are taller than the soldiers in our Civil War. The draftees in this war are not only taller, but they are heavier than the draftees 25 years ago. This could not have been the case were malnutrition as extensive in our country as was announced two years ago at the Washington conference, for chronic malnutrition impairs growth and produces underweight instead of overweight.

FAULTY FOOD PRACTICES

Nevertheless, our nation must take stock of our faulty food habits and our faulty food practices for the needs of today and tomorrow, in the case of a prolonged conflict, and for the certain needs of health rehabilitation in many parts of the world when firing ceases. Among our outstandingly faulty food practices is *food waste* in the kitchen and at the table. This is particularly true of food fats. We have developed the agricultural ideal that the fattest hog and the fattest steer is the prize hog and the prize steer. But in the case of the fat steer, most of that fat is wasted, at least as regards human food. Hog fat is used more economically, at least in part, as lard. But it is not only food fats in which we Americans have been wasteful. We do not consider it good form to clean our dinner plates before they are put into the dishpan. Our children are allowed to be wasteful with food, and they usually carry that habit as grown-ups. I have been around in many countries, and while it is true that food waste occurs among people in the upper income brackets in every nation, I know of no other country where the population as a whole has been as wasteful with food as in our own beloved U.S.A. This is *economic* waste, but when men, women, and little children in other lands are starving to death, there ought to be other motives to compel us to stop this food waste; that is, motives other than dollars and cents.

FOOD PROCESSING RESULTS

In our ignorance in years of plethora of good foods, we have developed practices in food processing and food refining that will cause serious injury to health in times of food scarcity. I refer to such processes as the modern milling of our wheat and rye into white bleached or so-called patent flour. I refer to such processes as are involved in some of our prepared ready-to-eat breakfast foods, prepared in many cases from our good cereal grains under conditions where

some of the most important nutrient elements are lost, and the proteins that are left are largely denatured or rendered inferior for human nutrition. The milling of patent flour and the preparation and consumption of these ready-to-eat breakfast foods under our ordinary peacetime variety of an abundance in diet would not be so serious. It is a fact that when the wheat bran from the flour mills is fed to hogs, chickens, and cattle, these get the better part of the grain. It is misleading to add two or three of the vitamins, and a little iron and lime to this denatured flour and call it "enriched," when as a matter of fact, that "enriched" flour or bread is still *impoverished*. When food is abundant, the gray squirrel and the rat eat only the germ of the corn and leave the rest. In our ignorance, we eat the rest and feed the germ to hogs and cattle. I have even heard this argument: that we must not mill more nutrients of the wheat berry into the flour for human consumption, because that will decrease our good cattle feed!

In the pro and con argument for milling more of the normal nutrient of wheat and rye into our wheat and rye flour versus our present program of "enrichment" or our defective patent flour with thiamin, riboflavin, niacin, and iron, one frequently hears that our people will not eat whole wheat or whole rye bread; that our bakers cannot bake a good loaf out of whole wheat and whole rye; and that the American stomach cannot tolerate and digest whole wheat and whole rye bread. Now, what are the facts in the case? Certainly, there are a few people with chronic gastro intestinal hyperirritability who would be seriously affected by the roughage in whole wheat or whole rye bread. These of course will have to have special diets, like some people afflicted with other types of diseases. But the American stomach and the American palate are not different from the stomach and palate of the people in Northern Europe and Russia, or the stomach and palate of the American Indian who ate whole corn when it was available. In Europe and Russian whole rye bread, and to a lesser extent whole wheat bread, have been human food staples for centuries, possibly for thousands of years. These people grow on it, they travel on it, they work on it, they love on it, they fight on it. I lived on whole rye and whole barley bread, essentially, till I was sixteen years old. The Russian soldier today stands up pretty well and fights rather well on this dietary staple. The American palate and the American stomach cannot have changed or deteriorated so greatly in the few decades or centuries since our forefathers left northern Europe. Human nature does not change that fast. And as to our people not eating whole rye or whole wheat when our customary bread is available, I think they will eat it with avidity, if they are hungry enough. According to Dr. Villijalmur Stefasson, dental caries, and frank vitamin deficiency diseases were not known among the Eskimos until the introduction of our processed foods.

FOOD WASTES

There is one serious waste of good human food which war necessity should compel us to correct. I mean the tremendous waste of skim milk. There is prevalent among us the superstition that the essential food value in milk is the fat thereof; that is, butter. So the saying has come about that when we take the essential value out of a situation or process, we have *skimmed* it. Now as to butter and skim milk, we now know that view is untenable. It is well established that it is false. For skim milk contains practically all the valuable proteins, valuable minerals, and some of the valuable vitamins of whole milk. Now, in our great consumption of butter and cream, the skim milk which is produced goes largely into hogs, chickens, and calves instead of the human stomach; and in many cases into commercial products such as glazed paper and glue not even as significant for our existence and health as cattle, hog and poultry feed. We should not allow this inexcusable waste of a superior human food—skim milk. We would have an additional insurance of good national health through better nutrition did we consume as whole milk, every drop of milk that we can possibly produce. Modern science of chemistry, and nutrition, can now produce a spread for bread essentially out of vegetable fats, a spread for bread nutritionally equivalent to butter. But we pass Federal and State laws to impede and present it.

In countries where the population is up to the point or beyond the number that can be sustained in abundant health by the products of the soil, the people on the whole are more *omnivorous* than we in the United States. They are so by necessity. We tend to look down on people as ignorant, inferior, or degraded, if they consume animal or vegetable products that we (in our ignorance) reject as foods. I am informed that neutral Sweden has put price ceilings on seagulls and crows. There are, indeed, very few cereal grains, legumes, tubers, vegetables or fruits that are in themselves poisonous to man, and there are even fewer such poisonous animals, when killed and prepared as meat products usually are, for human consumption. We could be, and in face of a real food scarcity, will be much more omnivorous than we are now. In fact, I am sure there would be a greater assurance of abundant health through adequate diets were we more omnivorous in times of peace than is our usual habit. Unless the one-sided diet is selected from few of our known superior foods, monotony in diet is apt to spell inferior health, because we do not as yet know everything in regard to optimum nutritional requirements for man either in the field of proteins, amino acids, minerals, or vitamins.

OBESITY

Food scarcity in war time could and should correct at least one type of malnutrition in our country, that is, the eating of good foods to the point of obesity. Obesity is a liability to health. There can be no question about that fact, especially in people 40 years of age or beyond. To be sure, we have no accurate statistics of the prevalence of obesity in our land, but it is my impression that north of the Mason and Dixon line, obesity is far more prevalent than underweight. I think adequate hospital statistics would bring that out. Statistics in the case of one large life insurance company reveals the fact that among its policy holders, obesity (more than 10 per cent above standard) runs 28 per cent, while underweight (more than 10 per cent below standard) is less than half of that, or 12 per cent.

THE VITAMINS

The conspicuous advance in the realm of vitamin chemistry, physiology and medicine in the last 25 or 50 years has led to the Utopian hope that maybe many, if not all, of our common ailments, including inferior energy or "pep," and inferior intelligence, are due to vitamin deficiency and can be cured by the 1944 vitamin pills. So the daily press and the hourly radio diagnoses of human ailments, and prescriptions of what vitamins to take cover the page and fill the air. Is vitamin deficiency the main factor to be dreaded or avoided in our war time food problem? I saw plenty of war-

time undernutrition in the war-devastated countries in Europe from the Adriatic to the Polar Circle at the conclusion of World War I. The outstanding, conspicuous food deficiency revealed by that population was deficiency of proteins and calories, resulting in hunger edema, loss of weight, retarded growth in children, and tuberculosis and other infectious diseases. When such foods as milk, eggs, meats, poultry, and fish seriously decrease or entirely disappear; when the cereal grains are denatured by modern milling, protein deficiency is not far away. And since the immune bodies are proteins, and proteins are needed in their production, infectious diseases will rise with the diminuation or disappearance of foods of animal origin and milling the germ out of wheat, rye and corn. The intake of fats will also decrease, and the calorie needs have to be met largely by starch. However, it is not impossible that protein deficiency alone might account for the overall loss in body weight in the children that I saw in war-devastated Europe in 1919. Calories might be adequate, and the condition would still have been as I saw it. At least that is the present indication of animal experimentation. I believe this is an important point to be always kept in mind by the medical profession in advising or guiding governments or patients as to foods and diets in wartime. And there is special responsibility on the shoulders of physicians and nurses in wartime in the matter of special diets for special diseases. Such special needs should be real, not merely traditional, and the special allowances should reach the patient's stomach, not other stomachs.

The recommendations of the Food and Nutrition Committee of the National Research Council nothwithstanding, the fact is that we do not yet know the optimum vitamin needs of man. Our country has been rendered *vitamin conscious* by the press, the radio, and the less critical laboratory and clinical workers in nutrition. The detail man is so eloquent and persuasive that even the most competent and conscientious physician is in a dilemma. Clinical recognition of vitamin deficiency in our populaton is now rare, except for pellagra in the south. Laboratory and clinical tests detecting insipient vitamin deficiency are as yet largely in the experimental stage. But lest we overlook a bet, too many of us jump on the vitamin bandwagon. Even our Councils of Pharmacy and Chemistry, and of Food and Nutrition (A.M.A.) have given provisional approval of the old shot-gun therapy in the form of commercial vitamin mixtures (*J.A.M.A.* 1942, Vol. 119, page 948). There are particular difficulties in connection with the possible needs of vitamin B complex, both in apparent health and in definite disease, since some of these vitamins are important in the proper functioning of the nervous system, such as mental and physical endurance, mental alertness, mental and physical fatigue, etc. And, certainly, we need our brain and our muscles working at highest competency if we are to win this war in a reasonable time. So many tests have been made to find out whether vitamin pills added to the usual diet of people in industry and in offices will increase production and lessen fatigue. That line of work is full of pitfalls because mental fatigue is in part a question of interest in the work at hand, rather than of an adequate diet; and it is further true that increased susceptibility to mental fatigue, from mental and physical work, is present in diseases other than those due to defective diets, although such increased fatigability undoubtedly will follow any chronic deficiency in calories, proteins, and vitamins as well as organic salts. Quantitative determinations of fatigability are full of pitfalls, especially in the uncontrollable psychological factors, and call for so much time, both on the part of the patient and the physician, that this method is virtually out of the question, even in our best hospitals. Merely recording the patient's opinions on his history sheet gives no reliable data to the doctor, and contributes little or nothing to medical advance.

Drs. Holt and Nadjar of Johns Hopkins Medical School have recently reported the important discovery that the usual bacteria in the human alimentary canal manufacture thiamin, in some cases in sufficient quantities to meet the needs of the body, at least for a while, without any of this vitamin being present in the diet. Dr. W. H. Sebrell is probably correct when he says that "almost all practicing physicians are now prescribing vitamin preparations for more and more of their patients." But when Dr. Sebrell adds that "this is significant," I am compelled to ask: significant of what? Direct advertising to laymen undoubtedly sells more and more vitamin pills to these laymen on their own diagnosis of real or imaginary ills. *Neither fact proves the need for vitamin pills for the abundant health of the people.* There was a time when physicians prescribed more and more phlebotomy. The only significance of that fact was lack of understanding of that generation of physicians. If, as some colleagues claim, constipation, irritability, fatigue are nutritional deficiency diseases, it is clear that all of us need additional vitamin nearly all the time, even in peace; that is, if we do any serious work at all. But chewing gum, cigarettes, and Carter's Little Liver pills also promise that needed "lift," that abundant "pep." And how can we neglect that dreadful "acid side" of life, which Alka Seltzer promises to convert to a cheerful bathroom yodle in the morning?

It should be evident to every informed physician that a marked and chronic impairment of hunger and appetite, from any cause whatever, may ultimately lead to some degree of malnutrition, even when plenty good foods are available. Is the reverse also true? Does starvation, does deficiency in one or in all essential food factors, lead to decreased appetite? Some nutrition workers, some otherwise competent physicians say: "yes." This view is largely based on laboratory tests on rats, with diets lacking in the Vitamin B complex, specifically thiamin. But is it true for man, especially in the usual phases of undernutrition, due to food scarcity because of war? My experience with fasting and starving rats, dogs, men, and nations says: *No.* And that is also the answer of general animal biology. If starvation short of death destroys hunger and appetite there would scarcely be left on earth any animal species, for food scarcity has faced most, if not all, of them from time to time for millions of years. The rat for a long time on a diet very deficient in the Vitamin B complex usually eats less and less of that food, but the same rat, unless moribund, will eat more and more of better foods, if he gets the chance. The story has it that Colonel Rickenbacher and his companions ate raw seagulls after some three weeks' starvation. Dogs fasted to such a degree of weakness that they cannot stand and cannot walk will eat, or try to eat, though they may be too weak to swallow. Severely malnourished, that is, undernourished people in the war-wrecked countries in Europe in 1919 ate with avidity, what to most well-fed people would be regarded as very tasteless, impalatable, if not actually disgusting foods. No, failure of hunger and appetite are not early and reliable criteria of wartime malnutrition.

NUTRITION PROBLEMS AND THE PHYSICIAN

But, owing to wartime food rationing, relatively scarcity of some of our good and usual foods, and consequent changes in our usual menus; further, because of the current stress on foods and nutrition, some of it wise, some of it otherwise, the physician will have increasing

calls to eliminate or establish undernutrition in his patients. How can he do it? If we shut our eyes and merely prescribe vitamin pills (even with the minerals included) we will, in most cases, render a disservice to our patients, our science, and our country. It is easy to say: first eliminate all other disease. But this is extremely difficult to apply, as malnutrition and other diseases may coëxist. But this, at least, is true: even in the total absence of all other diseases, *significant undernutrition in the child will retard growth and reduce body weight significantly below the average. Significant undernutrition in the adult will reduce body weight much below the normal average.* Of course, edema from insufficient proteins is an exception. We have quantitative measures of body height and of body weight. If we project all other tentative criteria of undernutrition against these factual base-lines, we will render full service to our patients and to our country in the matter of food and war, and we will commit no major sins against science.

Since adult men and women, starting with good average health, can live from 40 to 70 days without any food whatever (including vitamins), it is clear that the minimum food allowance for mere existence is much lower (both in energy and in other essentials) than the minimum ration for reproduction, optimum growth, maximum work, and maximum resistance to infections, assuming comparable climates. But rations providing mere existence are a biological futility. When food sources fall that low, war ends and reproduction should cease voluntarily, in fairness to the mother, the child, and the nation.

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CALIFORNIA'S FOOD PROBLEM IN A WARTIME NUTRITION PROGRAM*

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THE most compelling reason why the medical profession can well afford to take an interest in the food and nutrition program of California, is quite a selfish one. The physician is bearing an excessive burden in caring for the sick. Adding a decreased well-being of patients as a result of malnutrition, makes his burden still heavier.

It is readily understandable why the enthusiastic nutritionist feels that the physician has not shown the interest in the application of food to well-being that present knowledge of nutrition seems to warrant. The nutritionist, however, is apt to overlook the fact that nutrition is a new science, whereas medicine is, by comparison, an old one.

Dr. Frederick J. Stare, of Harvard University Medical School, presented the broad reasons why the medical profession does not yet wholeheartedly embrace the doctrine of "excellent nutrition." Dr. Stare reasons that clinical medicine thinks in terms of disease and pathology, instead of in terms of health, of preventive medicine or long time results.

Another reason, cited by Dr. Stare, is that the physician still lacks objective evidence that optimal nutrition is really a factor of major importance in the run of the mill diseases seen in the general practice of medicine.

The exigencies of war seem to have made America—even blockaded England—a healthy nation, regardless of certain food curtailments.

The answer lies partly in the better use of available foodstuffs, which became an immediate basic consideration in planning and administering a nutrition program when supplies are curtailed by extraordinary wartime demands even in the face of increased production.

FOOD AND NUTRITION

Food and nutrition, unfortunately, are NOT synonymous. Food has always been the most critical of all war materiel. Its abundance "toughens the sinews of war," and, conversely, its lack becomes a powerful solvent for "softening up" the fighting man and the civilian alike. In addition, the nutritionist has a keen appreciation of the relationship of specific food factors necessary to physical well-being. He has seen nutrition surveys showing the high percentage of population not eating a sufficient amount of the proper foods even when they are available. He consequently sees curtailment of meat supplies not only as a threat to protein adequacy, but as a problem of meeting the niacin requirements set up in the "yardstick." His outlook and viewpoint naturally are colored by more meticulous scientific thinking habits, and it often becomes more difficult for him to adapt himself to the broader use of food as sustenance.

Essentially, there is no scientific conflict between a program based on an academic concept of nutrition and a realistic war food program. It is a question of practical approach to the limitations and dislocations of life under wartime conditions. The American fighting man in a foxhole does not get a scoop of ice cream on his apple pie. He does not expect to find either in his K-ration. He does receive the utmost in concentrated calories and essential nutrients to keep him as well-fed as is scientifically possible.

To be a civilian service for the people of California, a nutrition program had to be one to aid the civilian to obtain and utilize the food he requires to satisfy his needs. Basically, a wartime balanced food and nutrition program—whether for California or the entire United States—must call for one founded on foods which are economical sources of nutrients. By economical, is not meant solely the dollar and cent value or price paid by the ultimate consumer, but economy in terms of manpower and other factors, influencing the production and distribution of food.

Wartime food production planning no longer concerns itself solely with total production of calories. It must share fats with the munitions makers for glycerin. It must remember the xerophthalmia in Denmark in 1917 which had exported butter, its food source of vitamin A without providing a nutritional alternate. Critical food gaps must be bridged to prevent, as far as possible, endemic nutritional damage.

Pellagra and scurvy are no less deficiency "end states" in the patient of higher economic level with a perverted appetite than in the poverty-stricken or nutritionally uninformed. Niacin or ascorbic acid know no class distinction in their physiological effects.

BORDERLINE NUTRITION

The physician has the first and most consistent opportunity for viewing the intermediate, as well as the end results of poor nutrition objectively. The work of clinical investigators in borderline nutrition activated the National Nutrition Conference, held in Washington, in May, 1941.

Section IIIa (Public Health and Medical Aspects of Nutrition) met under the presiding chairmanship of Dr. James McLester. Its recommendations to the conference body included the following:

"That efforts be made to stimulate greater interest in nutritional problems among general practitioners, and with this in view that opportunity for post-graduate training in nutrition be made more widely available.

"That medical societies, dental societies, and health

* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

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authorities be represented in all State and community nutrition committees, and that medical groups take an increasingly active part in organizing, sponsoring, and coöperating in nutrition programs.

"That medical societies be asked to form nutrition committees for the purpose of disseminating nutrition information through symposia, speakers' bureaus, exhibits, motion pictures, and similar methods."

DIETARY DEFICIENCIES: RÔLE OF THE PHYSICIAN

The practicing physician is in a strategic position, it was pointed out, not only to recognize dietary deficiencies, and to advise the individual patient, but to help guide community planning for nutrition, weaving it, as Dr. Casparis said, "into the fabric of the individual."

Many practical nutritionists, like Miss Frances Stern of the Boston Dispensary, held the view that the medical practice of prescribing vitamin pills, rather than food, is due to two factors: (1) the unwillingness or inability of some physicians to calculate food values properly, and (2) the yielding to the patient's insistence for a vitamin prescription, because it was the "easiest way out."

In summary, Dr. McLester stated, the physician should teach people to eat good food, and in that way prescribe vitamins in terms of food.

Thus it was hoped that the physician would become a most influential force in the nutrition program. As the family's medical advisor he holds the confidence of his patients. The industrial or plant physician likewise is in a position to advise management to provide adequate feeding facilities for employees. He can suggest that competent advice on the technical problems of in-plant service of nutritive foods is readily available through the Federal, State and even local nutrition committees.

SOME CALIFORNIA PROBLEMS IN NUTRITION

The war brought sudden and specific problems to challenge California's original nutrition goals. Almost overnight California became a vast armament plant. War contracts transformed the State into one of the greatest industrial areas in the United States. Workers streamed here to man the assembly lines of shipyards and aircraft plants. The food habits of these newcomers were different, and often inferior in nutrition to those of the acclimated. The wholesale entry of women into industry disrupted food-planning and meal preparation in the home. Agricultural production was dislocated by the transfer of farm workers into industry and the armed forces. Meat shortages occurred in California before they did in other sections of the country. Californians were asked to "share the meat" at a time when there was little meat to share.

Thus, to the informed layman the word "nutrition" became a *desideratum*. To the uninformed laymen nutrition still meant only vaguely "eating the right foods," with no real understanding of what the "right foods" might be. Rationing meant an "opportunity to get enough food," rather than sharing.

California's wartime nutrition program, viewed realistically, became primarily a food program into which all major factors and interests affecting food, and its use, had to be called into action:

1. Food production must not be permitted to lag, whether on the broad acres of agriculture or on the home-plot of the Victory Vegetable Garden. Consequently, "flash surpluses" of perishables, such as cabbage, eggs, onions, potatoes, peaches arise to perplex the consumer who has been warned to expect curtailment of food supplies in war. It means emphasis by the various agencies, assisted by the direct contact the State Food and Nutrition Committee has established with the consumer through local or community food committees, to use such surplus food products in greater quantities than prevailing food habits might normally account for. Encouragement by the physician that the family coöperate with these local programs may not seem "medical advice," but quite directly affects health.

2. Food distribution must be kept as orderly as possible, implemented to meet emergencies wherever and whenever necessary, so that edible food shall not go to waste.

Taste and waste are two very difficult problems in meeting war food requirements. They are, however, hedges against hunger. As belts are tightened, willful waste decreases. Left-over butter pats are harder to find in restaurants today.

3. Food conservation is definitely a part of a wartime nutrition program. Conservation encompasses both the elements of fighting food waste in the home and of preservation, whether by canning, brining, drying, freezing, or whatever method is best suited to its storage with the least loss of nutrients. The home conservation program required guidance and supervision. Many "put up" food for the first time, other newcomers did it for the first time in California without recognition of greater hazards, such as botulism, etc.

On the other hand, California has inherent advantages. It has a twelve-month growing season for many of the protective foods, contrasted with the average of seven months for the rest of the United States.

AN ORDERLY PROGRAM FOR CALIFORNIA

What, then, stands in the way of an orderly food and nutrition program in California?

1. The very prodigality of food resources in the past has led to wasteful practices which have no place in a wartime food economy. Approximately fifteen per cent of the edible portion of the food purchased by the American household is wasted. Elimination of all edible kitchen and table waste automatically would increase the available and already distributed food supplies by 20 to 25 per cent.

2. California's racial food patterns are more complex, because they involve larger segments of our population adhering to original cultures. The food pattern of the Spanish-Mexican, and also the Chinese is more rigid than that of the Italian.

Sudden disturbance of a fixed racial food pattern may seriously upset its nutritional balance. Often the racial pattern is barely adequate, as in the case of the Mexican diet, where a curtailment of beans, either by shortage or high ration-point value, would produce a definitely low protein intake, unless a compensating protein alternative, acceptable to the Mexican palate and culture, were made available. Meat and cheese would become the nutritionist's answer. In the wartime demand for increased meat to meet a bean protein shortage, the food economist would regard the nutritionist's solution as another "let them eat cake!"

The Oriental food pattern is even less understood, although it was the subject for the first nutrition study in California, when Atwater published his nitrogen balance studies on Chinese laundry workers and a family of Occidental "fruitarians" at the turn of the century.

The Italian pattern is more flexible. It permits adjustments in the light of projected food supplies, other than cheese, in California. Cheese, on the other hand, is of no concern to the Oriental pattern of which it has never been a part.

These and many other factors enter into a nutrition program, and must seem strange to those accustomed to looking on nutrition through the lens of the laboratory microscope. Nevertheless they are real. They have become part and parcel of an orderly program for adequately feeding our California population.

They further constitute individual problems, one of which may exist only in San Mateo or Vallejo, and another which affects Riverside. There can be, unfortunately, no *fixed* Statewide program.

PUBLIC EDUCATION

The alternative, therefore, is public education in food problems and food use for nutrition. For such a program intelligent leadership is needed, because food science in terms of nutrition is still new. Education requires the willingness of those-who-know to pass sound information on to those-who-need-to-know. The physician will be "one who is asked," as the public's interest grows more pointedly "technical."

The public, however, must not be confused by technical knowledge and rapidly-changing scientific findings of great interest to the nutritionist alone. To convey pertinent and helpful food facts requires organized discussion-groups, headed by competent leaders. To put the facts, so learned, into actual practice in the form of nutrition requires discussion leading to group-decision "to do something about it." Research in nutrition teaching methods show that there is no comparison between the "cold" lecture method and the group-discussion-with-decision method when it comes to tabulating the results in the form of improved food habits in a community.

Trained individuals will be needed for leadership in their communities to determine the most pressing nutrition problem in the community, whether it be a nutritionally unbalanced school lunch or the establishment of in-plant feeding in a crowded war industry, and then to aid in solving the problem. Translated into actuality it means the maintenance of an authoritative food information and nutrition committee in every community. In most communities local food and nutrition committees have been formed, working on local problems. Some, unfortunately have had to carry on with little or no participation by the physicians of the community.

Poor health, resulting from malnutrition, these physicians argue, is a matter of individual concern until it is severe enough for the physician to repair the damage. Infant health and maternal welfare are now shown to be so benefitted by sound prenatal nutrition advice that this position must seem untenable even to the layman.

San Bernardino County's nutrition objective centers around just such a coöperation between its medical society and the community committee in a prenatal nutrition advice program.

Programs, such as these, bridge the gap between dietetics, as practiced by the clinician who is treating the diabetic or the obese patient, and his teaching the use of food by the well-patient who will soon be called upon to undergo more than normal demand on her metabolic processes. It emphasizes, too, the need for real nutrition courses in medical schools, not merely for pediatrics, but for obstetrics, surgery and general medicine.

Such basic training will enable the physician to judge better between the overenthusiasm, bred by the newness of nutrition, and the ultra-conservatism so obvious from the almost stereotyped "W D and N" (well developed and nourished) on so many clinical diagnosis charts.

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Landry's Paralysis.—In 1859, in a well-arranged report entitled, "Note sur la paralysie ascendante aiguë," the French physician, Jean Landry, gave his original description on the acute ascending spinal paralysis. Since then this disease has justly borne his name, and today still is recognized as a clinical entity. It is a rare disease in which the paralysis is sometimes descending instead of ascending.—Warner's *Calendar of Medical History.*

WHAT CONSTITUTES A NORMAL DIET*

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A NORMAL diet provides all essential nutrients, bulk and fluids, in sufficient amounts and suitable form, for growth and repair of tissues, energy needs, and regulation of body processes.

THE PHYSICIAN'S RESPONSIBILITY

Since people look to their doctor for advice and guidance on family problems, he has the opportunity to impress upon the homemaker the tremendous importance of her position as it relates to the family health and happiness. She should be advised that she has a real opportunity and a challenge; she must have the imagination of an artist in planning attractive meals, the cleverness of a showman to present an adequate diet to a family with various food likes, the economist's knowledge of supplies and shortages, and the food chemist's knowledge of food preparation to retain values. The successful homemaker today takes her place with other soldiers of production. She should be entitled to recognition for outstanding accomplishments. If the doctor has the coöperation of a family, fed by a mother who fulfills these "specifications," he will have no cause for concern over a normal diet for the family.

A NORMAL DIET

In order to conserve space, practical information concerning the requirements of a normal diet, conservatively estimated from reliable sources, using commonly-available foods in acceptable portions, is presented in tabular form with a minimum of explanation.

Recommended daily allowances for calories, protein, calcium, iron, and specific vitamins are tabulated for men and women by activity, and for children by age groups, by the Committee on Foods and Nutrition, National Research Council.

The Basic Seven Classification of Foods† is accepted by nutrition authorities as a simple means of presenting general information on a normal diet. It is used to interpret the Recommended Daily Allowances for Specific Nutrients for various members of a family group in terms of household measurements, in Table 1.

ANALYSIS OF INDIVIDUAL'S DIET

The first six groups and amounts suggested in Table 1 meet a little more than the basic caloric needs—they meet also the protein, mineral, and vitamin requirements. They outline the fundamental diet considered essential to health for each individual. This outline may well be used as a guide in checking adequacy of food intake as a part of physical examinations. It is the foundation upon which therapeutic diets are built. Group 7—Fats—provides calories and makes possible a more concentrated diet, especially important for those with small food capacity; it also adds more Vitamin A. The Riboflavin content of the diet in Table 1 is on the borderline, unless special attention is paid to choice of individual foods.

RICH FOOD SOURCES OF PROTEINS, VITAMINS, AND MINERALS

Because everyone does not select his diet carefully, or

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Nutrition Department of the Los Angeles City Health Department.

† See the National Wartime Food Guide, U. S. Dept. of Agriculture, War Food Administration, Washington, D.C. (Form NFC-4 Rev.)

may not tolerate certain foods, good food sources of proteins, vitamins, and minerals are listed to assist in the inclusion of adequate amounts of specific nutrients.

Protein.—The protein recommended for the average male adult is 70 grams, or one gram of protein per kilogram of body weight. Each food listed in Table 2 contains approximately 7 grams of protein. One-half of the protein should be chosen from animal sources. Ten portions meet the daily protein need. A man may obtain his recommended protein intake by eating the protein-rich foods noted in the one-day's diet shown in Table 3.

Vitamins.—Vitamin A, recommended for the male adult, is 5,000 I.U. per day. Vitamin A (pro-vitamin A) is found in dark green and yellow vegetables, and is fairly stable. At least one serving of leafy green or yellow vegetables, plus some animal source of Vitamin A, should be included in the daily diet to assure requirements.

Vitamin B.—Food sources, commonly available, of three members of the B Complex, for which allowances have been recommended in the human diet, are shown in Table 4*. Average servings of edible portions of foods are given, with no allowance made for cooking losses. Note (from chart) that the addition of brewers' yeast and wheat germ may greatly improve the average diet.

Vitamin C.—The male adult allowance of 75 mg. per day may be obtained from one large orange, 5 oz. of orange juice, or ⅝ of a large, raw, green pepper. One-half to two-thirds is contained in ½ medium grapefruit or cantaloupe, 2-5" stalks of broccoli (steamed). An average serving of tomato, raw cabbage, potato (cooked in jacket), or cauliflower will provide 1/3 of the day's need.

Citrus fruits, tomatoes, or large raw salads are daily essentials in the diet, otherwise great care must be exercised in selection and preparation of foods of lesser value. A large serving of citrus fruit, or glass of tomato juice and a raw salad provide Vitamin C for the day.

Minerals.—Calcium allowance for male adult is 0.8 grams per day. This may be met with 1 pint of milk, plus 1 ounce of cheddar cheese, or ½ cup of cooked greens. (Turnip, mustard, collards, kale, or broccoli). Oranges, dried figs, canned salmon with softened bones, beans, and corn tortillas are fair sources of calcium.

A diet of beans and tortillas may provide calcium and phosphorus in proper ratio, and also sufficient calcium when eaten in large amounts. However, it may lack essential amino acids and other vitamins found in milk. Therefore, special emphasis should be placed on cheese and green vegetable additions.

Iron.—Iron allowance for male adult is 12 milligrams per day. From the iron-rich foods (each containing 1½ mg. of iron) listed below, choose daily at least 8 portions for men, women, and children over age 7; 10 portions for adolescent boys and girls; 10 portions for pregnant women.

⅔ oz. liver; 2 oz. lean meat; 1 egg
⅔ cup cooked oatmeal; 1 cup whole wheat or cornmeal
3 slices whole grain or enriched bread; 3 cups milk
2 tablespoons wheat germ; 1 tablespoon molasses
3 halves apricots; 4 prunes; ¼ cup raisins (seeded)
7 dates; 4 small dried figs; ½ medium avocado
½ cup cooked greens (beet tops, chard, kale, mustard)
½ cup cooked dry beans; ½ cup peas; 1½ medium potato

Instead of taking 10 separate items from suggested list, one may use several portions of one food, such as 3 ounces of liver (which would give half of the day's allowance), and to this should be added 2 servings of green vegetable, ⅔ cup of oatmeal, and 1 tablespoonful of molasses or 2 tablespoonsful of wheat germ. A varied diet using foods, in natural state, usually assures sufficient iron and copper, the latter being a dietary essential which is associated with iron in food.

Know How to Get the Maximal Values Out of Foods. Vitamins, mineral, and protein values may be reduced or destroyed by heat, light, air, and water. Therefore, the physician should make available to his patients, confused by information from unreliable sources, the changing information on retention of values and selection of foods, which continuous research is bringing to light. Since the busy physician, who has no dietitian in his office, has little time to evaluate this changing stream

* Due to limitation of space Table 4 has been omitted. One may secure Table 4 by writing to the author.

TABLE 1.—*Practical Interpretation of the Normal Diet for Individuals in the Family Group Using Basic 7—Classification of Foods**

Food Group	Food	Moderately Active Man (154 lbs.)	Moderately Active Woman (125 lbs.)	Pregnancy Latter Half	16-20 Year Old Boy	13-15 Year Old Girl	10-12 Year Old Child	4-6 Year Old Child
I	Green and yellow vegetables	½ cup	½ cup	1 to 1½ cup	½ cup	½ cup	½ cup	¼ cup
II	Oranges, ½ grapefruit, tomatoes, cabbage, green salad	1 med. or large serving raw	1 med. or large serving raw	1 med. plus large serving raw	1 med. plus large serving raw	1 med. plus salad	1 med. plus salad	½ med. plus small salad
III	Potatoes	1 medium	1 medium	1 medium	2 medium	1 medium	1 medium	½ medium
	Other vegetables	½ cup	½ cup	½ cup	½ cup	½ cup	½ cup	¼ cup
	Other fruits	1 serving	1 serving	1 serving	1 serving	1 serving	1 serving	½ serving
IV	Milk to drink or milk in food	1 pint	1 pint	1 quart	1 quart	1 quart	¾ quart plus 1 oz. cheese or milk dish	¾ quart plus small milk made dish
	Cheese			Am. 1 oz.				
V	Meat, poultry, fish, eggs, dried beans, peas, peanut butter, nuts	½ lb.	⅜ lb.	⅜ lb.	½ lb.	⅜ lb.	5 oz. or 5/16 lb.	3 oz. or 3/16 lb.
VI	Bread—whole grain	2 slices	1 slice	3 slices	3 slices	2 slices	2 slices	2 slices
	Bread—enriched	3 slices	2 slices		3 slices	1 slice	2 slices	
	Cereal—whole grain	⅔ cup	⅔ cup	⅔ cup	1½ cup	⅔ cup	⅔ cup	⅓ cup
VII	Butter or fortified margarine	3 oz. or 6 T.	2 oz. or 4 T.	3 T.	3 oz. or 6 T.	2 oz.	2 oz.	1 oz.
	Fats in cooking or salads	from VII	from VII		from VII			
Extras as choice or for calories	Sugar or Sweets	1 to 2 T.	1 to 2 T.	1 to 2 T.	2 T.	1 T.	2 T.	1 T.
	Desserts—as pie, cake	1	1	1	2	1	1	
	Pudding, Ice Cream, or preferably extra fruits		Extra green vegetable		Extra ice cream or milk dessert			

T=Tablespoon

This table gives specific amounts of food to meet B complex requirements without cooking losses. Therefore add extra B values in extra calories selected.

of information on research in foods, as to methods of preparation and practical use, he may check occasionally with the nutrition division of the local or State health department, or the extension division of the State college of agriculture, for unbiased interpretation of the trends.

A few examples are: The potato steamed in its jacket might often replace the baked potato prescribed for infants; the family oatmeal may be strained for the baby; the whole orange may be eaten instead of juice, when conditions permit; evaporated milk may be used in cooking and concentrated diets; utility cuts of meat may be prepared in a palatable manner.

TABLE 2.—*Foods Which Contain Approximately 7 gm. of Protein (1/10 of the Daily Allowance for an Average Adult)*

Animal Proteins	*Vegetable Proteins*
1 glass milk	½ cup dried beans cooked
1 oz. cheese	2⅓ slices bread
1 egg	1 oz. nuts
1¼ oz. meat	2 T. peanut butter
1¼ oz. fish, poultry or rabbit	⅔ cup cooked cereal

TABLE 3.—*Foundation Menu Providing Daily Protein Allowance for an Average Man*

Breakfast	*Lunch*
Cereal—⅔ cup	Sandwich (with filling of meat, fish, cheese, nuts or eggs) or
Bread—2 slices	Beans—½ cup and bread—2 slices
Egg—1	Milk—1 glass
Milk—1 glass	

Dinner

Meat—¼ lb. (good serving **Bread—1 slice**
Total—71 gm. protein.

Careful Daily Selection to Provide Normal Diet.—Increased income has brought a wider use of luxury—and out-of-season foods, with a frequent poor selection of certain essential foods. It is important to stress, from childhood, the use of a wide variety of foods within each of the seven groups, in order that the various minerals and vitamins that are minute in quantity, be incorporated in the daily diet. For optimal nutrition, the calories should be chiefly provided from foods in their natural state, instead of great amounts of highly-refined starches or sweets. Without a daily consumption of a green or yellow vegetable, a citrus fruit, two or three other fruits or vegetables, a pint of milk, some animal protein, some whole grain cereal, a normal diet will not be attained. Diversion from this dietary pattern, over a period of time, may require correction for deficiencies that may result.

Los Angeles City Health Department, 116 W. Temple St.

Physician Decries Vitamin Buying.—Spending by American people of $25,000,000 this year on vitamins is a deplorable waste of money, in the opinion of Dr. Herman L. Kretschmer of Chicago, president of the American Medical Association, recently in Denver for sessions of the Colorado Medical Society.

"Very few people in this country suffer from vitamin deficiency," Doctor Kretschmer said. "Such deficiency diseases as scurvy, rickets and pellagra have been almost wiped out."

He added that he did not want to decry the magnificent achievements that have been made in recent years by vitamin chemistry, but added, "I think it is ridiculous for people to expect radio announcers and grocerymen to prescribe for their health."

According to Doctor Kretschmer, vitamins should not be taken indiscriminately, but under a doctor's orders.

HOW TO MEET THE NEEDS OF THE NORMAL DIET WITH RATIONING OF FOOD*

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A BRIEF survey of the present food picture, as a whole, and of the problems it presents, is necessary if ways are to be found for meeting this issue satisfactorily.

First. Among the foods now rationed, or of which there is a threat of shortage, are milk, cheese, meat, and canned and frozen fruits and vegetables. Careful thought needs to be given to the means of compensating for nutritive losses which may result from the necessity for reduced consumption of these foods, all of which belong to the group of "protective" foods.

Second. The foods of which there is promise of abundance are the grains and grain products, such as bread and cereals and the dried legumes. This means that the extension of their use may be accepted as a necessity. It means further that dependence may need to be placed on grains and legumes to replace, insofar as possible, nutritive values lost in reduced consumption of milk, cheese, eggs and meat. They will also help replace shortages in fats and sugar. Grains and legumes should now be scrutinized for their "protective" qualities, and careful consideration must be given to the kinds of cereals which are available, and to the methods by which they have been refined or prepared.

Third. Essentially all forms of fat are now rationed. Butter may and will become increasingly short if the milk supply is to be protected. The loss of Vitamin A normally consumed in a good grade of butter will be covered if margarines, reinforced with Vitamin A, continue to be available in reasonable amounts. If, because of their lower point values, fats other than butter are selected by the consumer, the intake of plant-rich sources of provitamin A, or carotene, must be increased if the Vitamin A allowances are to be met. The consumption of fat-rich foods, such as peanuts and peanut butter, and soy beans and nondefatted soy bean products, may need to be increased in the diets of manual workers if the program of three meals a day commonly followed in this country is to furnish the energy required by them at reasonable cost. Furthermore, scraps of meat fats often wasted in the household must be conserved, and ways must be sought for using them. Homemakers must learn to render, to clarify and to make savory and acceptable all fats which reach the household.

Fourth. Serious threats to the adequacy of many diets result from the rationing of canned and frozen fruits and vegetables, and the cost of many fresh fruits and vegetables. Every encouragement should be given to the purchase of those fruits and vegetables which are of greatest nutritional value. Victory garden and home-food preservation programs should be urged.

Fifth. The rationing of sugar has been beneficial rather than otherwise, for the nutritional values of sugar are limited almost entirely to calories and seductive flavor. Increased use of grains and legumes may compensate for the loss of calories from sugar, and may contribute other important food values as well.

OBJECTIVES IN ACHIEVEMENT OF A NORMAL DIET

In the effort to achieve a normal diet in the face of shortages of many common foods, there are three objectives to which special attention needs to be given. In large part, a satisfactory solution of the problem of

* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

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good nutrition centers in them. These objectives are to provide sufficient protein of good quality; to furnish adequate amounts of minerals, particularly of calcium; and to supply a diet high in all essential vitamins, particularly Vitamin A and riboflavin.

Perhaps the most immediate problem is that of supplying an adequate amount and quality of protein. The new knowledge of nutrition emphasizes the importance not only of a reasonable total daily consumption of protein, but also the significance of the quality of protein. Protein foods are being rated as good or poor in quality in terms of their amino acid content. Specifically, this means that proteins are rated according to the amounts of each of the ten "essential" amino acids contained in them. A goal in the attainment of normal nutrition, therefore, is to include in the day's meals those foods which will furnish the needed abundance of good quality protein. Animal foods, milk, cheese, eggs and meat, all contain proteins of superior quality. The major plant sources of protein, grains and legumes supply proteins of lower quality than those of animal foods.

One situation which gives the nutritionist growing concern is the poor quality of protein in those grain foods which have been highly milled or impoverished, and especially of the white bread in common use in this country. The removal of the germ and aleurone layer from wheat in the manufacture of white flour takes from wheat its proteins of highest quality, proteins in themselves of value sufficient to provide for moderate growth and good maintenance, and leaves behind only proteins of poor quality. In addition, by far the larger part of the minerals and vitamins of wheat are also lost in this process. In this period of food shortages, the enrichment of flour through the addition of three vitamins and one mineral does not entirely compensate for the losses of proteins of high quality, or of some of the other twenty-five or more nutrients largely concentrated in germ and bran, which are sustained in the milling of white flour. Ordinarily this might not be serious. Now, however, it can assume such proportions as to cause actual physical deterioration. The use of whole-grain products is therefore, from the point of view of the quality of protein alone, of great importance at a time when the availability of animal protein foods is restricted. While dried legumes as a whole are richer in protein than grains, the quality of their protein content is inferior.

Wheat germ and debittered brewers yeast, if available, are both sources of proteins of good quality.

The second objective in which the maintenance of a normal diet may be threatened is in the supply of needed amounts of various minerals, particularly of calcium. While a possible deficiency of calcium is, theoretically, simple of solution, actually this may not be the case. Calcium is very unevenly distributed in foods, milk being the only food containing sufficient calcium to meet optimal calcium needs on any practical basis. Curtailment of milk in the diets of growing children, pregnant women and nursing mothers may seriously hamper the development and health of both child and mother. Deficiency of calcium in the diet of other adults, though less spectacular, in effect is also a health hazard. Calcium may easily be included in the diet in one of the many inorganic forms on the market, but understanding of the need for calcium and of this method of meeting it is not general, and should be greatly extended if milk consumption is reduced.

The third field in which there is a possibility for dietary deficiencies during rationing concerns itself with vitamins. Vitamin A may be much reduced in the diets of those persons who have depended largely on milk, cream and butter as its source. Increased use of the green and yellow fruits, and vegetables which are rich in the precursor of Vitamin A, carotene, may be relied upon, however, to overcome this shortage.

The food, whose common use in recommended quantities has been the most important dietary source of riboflavin, is milk. Next in importance, though not comparable in total amounts consumed, have been meats of all kinds and some vegetables. White flour has been enriched in riboflavin until it exceeds whole wheat products in this one respect. However, this difference becomes negligible in solving the problem of the riboflavin content of the diet as a whole. This may mean giving special consideration to all other available foods of good riboflavin content besides milk, meat and whole grains. Soy beans, peanuts, lima beans, eggs, broccoli, green peas, spinach and possibly other greens, sweet potatoes, wheat germ, dried yeast, are good sources of riboflavin.

Increased use of whole grain products and of legumes will do much to restore to the diet material amounts not only of thiamin, riboflavin and niacin, but of some other known members of the Vitamin B complex and possibly others suspected but not identified.

If citrus fruits and tomatoes are scarce or expensive, the Vitamin C content of the diet may be kept high through the use of foods such as raw yellow turnips (rutabagas), raw green cabbage, raw soy bean sprouts, and fresh fruits or raw vegetables as a whole. Potatoes, eaten in quantity, may make a valuable contribution of ascorbic acid, but must be supplemented with other sources of this vitamin.

SUMMARY AND CONCLUSIONS

There is no basis for apprehension on the part of the people of this country that their food needs may not be met on a reasonably normal basis. If, however, the needs of a normal diet are to be met with rationing and restrictions of foods, greater understanding of food values will be necessary, food habits will have to undergo modifications, food choices must be made thoughtfully, and home food production and preservatiion of food must be increased.

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THE PHYSICIAN AND THE OPA IN THE MANAGEMENT OF PATIENTS REQUIRING SPECIAL THERAPEUTIC DIETS*

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THE advent of food rationing has placed upon the medical profession the serious responsibility of prescribing food for persons who, by reason of impaired health, must have more of certain scarce foods than their allotment of ration points permits them to purchase. Recognizing this necessity, the Office of Price Administration authorized physicians to issue prescriptions for such foods in such quantities as the attending physician deemed necessary. Experience to date has shown that the great majority of physicians have taken this responsibility seriously and, recognizing the necessity for rationing, have been most circumspect and conservative in issuing food prescriptions. A very few physicians, however, have prescribed food in quantities which seemed excessive or occasionally without sufficient medical justification. It has been necessary to establish certain controls because of this very small percentage of the total number of physicians. The method usually followed by the Office of Price Administration has been to request

* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Office of the Medical Advisory Committee to the Los Angeles O.P.A.

local medical associations to designate committees of physicians who, acting as an advisory committee, examine food prescriptions and advise rationing boards as to whether or not the prescriptions are proper and reasonable.

The reader's attention is invited to the article entitled, "Food Rationing in Wartime," which appears on Page 422 of the October 16, 1943, issue of the *Journal of the American Medical Association*. It should be read by every doctor who prescribes food.

RECOMMENDATIONS OF NATIONAL RESEARCH COUNCIL

The Subcommittee on Medical Food Requirements of the Committee on Drugs and Medical Supplies of the Division of Medical Sciences of the National Research Council to the War Food Administration has prepared certain recommendations, setting forth the maximal allowances of rationed foods which, in the committee's opinion, should be prescribed for patients suffering from certain diseases, such as diabetes mellitus, tuberculosis, nephritis, cirrhosis, colitis, chronic suppuration, and sprue. The subcommittee based its recommendations upon opinions sought from recognized authorities on metabolic diseases and internal medicine throughout the country. There was much research and correspondence before this report was submitted. A typical recommendation is that for diabetes mellitus:

"Provisions for patients with diabetes mellitus may need to include per week not more than: meat, including fish and poultry, 64 ounces; bacon, 8 ounces; butter or margerine, 16 ounces; other fats and oils, 7 ounces; eggs, 7; milk, adults, 7 pints; milk, children to age 16, 7 quarts; fruits and vegetables, 72 ounces. This allowance applies only to processed fruits and vegetables. It does not indicate total carbohydrate requirements. If these amounts of food are not available to the patient from the rationed foods to which he normally would be entitled together with commodities obtainable from unrationed sources, sufficient supplementary ration points should be allowed to provide them."

OPA FORMS

Application for additional food allowances is made by the patient on OPA form R-315. An addendum to the application is executed by the attending physician, who is required to state the exact pathological condition which justifies the prescription; that the patient's health depends upon the consumption of such food, the reasons therefore, the amounts and types of foods required per week for not more than 10 weeks, and the reason why unrationed foods of similar type or nutritional content cannot be used. Processed food should be prescribed only when fresh products are unobtainable, or, for an adequate reason, cannot be used.

Physicians who use accepted scientific criteria in estimating the requirements of patients for whom they prescribe food will encounter no difficulty in having their prescriptions filled. The total amount of food lost through indiscriminate prescribing is perhaps trifling when compared to the total volume of food consumption, but it nevertheless has a serious effect on public morale. Moreover, the physician who yields to pressure and prescribes excessive quantities exposes himself to serious criticism, both of his motives and of his knowledge of dietetics.

429 North Orange Street.

"There is nothing more tragic than the murder of a big theory by a little fact, and nothing is more surprising than the way in which a theory will continue to live long after its brains have been knocked out."—*Thomas Huxley.*

SIGNS AND SYMPTOMS OF EARLY NUTRITIONAL DEFICIENCY*

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EVERY wise clinician is continually on the lookout for vitamin and nutritional deficiency diseases among the patients he sees, and not infrequently he may become conscience-stricken for fear that he is not recognizing deficiency states. Physicians and laymen have so often heard that symptoms, such as chronic fatigue, irritability, nervousness, lack of energy and pep, and a host of other frequent and nonspecific complaints, are the result of "not enough vitamins" that with them "hearing is almost believing." The public also is constantly reminded by specialists in advertising that those who partake of this or that vitamin-containing food in adequate amounts will overcome these common symptoms and find a Utopia of health. Obviously the public, and even the physician, becomes confused eventually, particularly because of the lack of clearcut symptoms and signs of early nutritional deficiency.

DEFINITION

A nutritional deficiency disease is a condition which arises when man or animal fails to obtain or to utilize a physiologically-indispensable amount of one or more of the essential nutrients.

THE NATURE OF NUTRITIONAL DEFICIENCY DISEASES

For the purpose of a clearer understanding of nutritional deficiency diseases and the difficulties which arise in recognition of them, it is helpful to consider the relationship between the intake and utilization of essential nutrients and the state of health. This relationship is illustrated by the diagram of Figure 1, and in Tables 1 and 2. Emphasis should be placed on the well-established fact that there is an optimal level of requirement of the various nutrients, and that, other things being equal, the regular intake and utilization of an optimal diet will lead to and be associated with what has been called buoyant health. The optimal level for all the essential nutrients has not been established, but figures have been widely accepted for many of them. There is good reason to believe that an intake of vitamins and minerals in excess of the optimal amount of each will not result in a condition of "super health," and that such excess amounts are either destroyed, eliminated or occasionally stored in tissues.

Further observations indicate quite definitely that there is also a minimal or physiologically-indispensible level of requirement for some if not all of the essential nutrients. When such a minimal level of requirement of one or more of these substances is satisfied, the resulting state of health of the animal or man may be said to be passable, and evidences of deficiency will not be apparent by ordinary clinical observation. (It is possible, of course, that quantitative study of chemical function might indicate a slight abnormality in certain enzyme systems under these circumstances, but for practical purposes such a possibility can be ignored at present).

Furthermore it is quite apparent that there is a wide zone between the optimal and minimal levels of requirement, as illustrated in Figure 1, although the figure is

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

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diagrammatic, because of lack of information concerning the amount of the difference between these two levels of requirements.

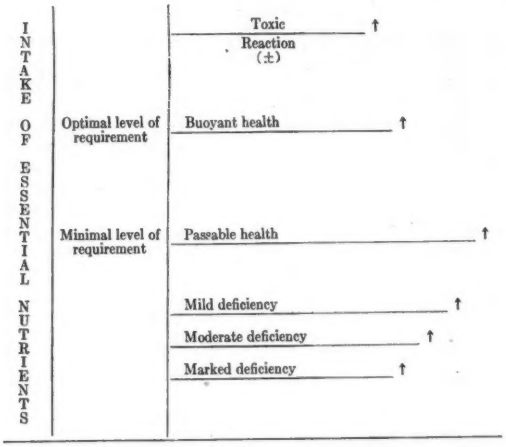

Fig. 1.—Intake of essential nutrients. Effect on health.

Whenever the intake or utilization of an essential nutrient falls below the minimal level of requirement for the substance, a deficiency of it may be said to exist. So far as we know, the first manifestation of such a deficiency is one of tissue depletion. Subsequently, with continuance of tissue depletion or further decrease in intake or utilization of the substance, a "biochemical lesion" may develop. Greater deficiency will lead to functional changes in the tissues, and subsequently, to anatomic lesions. While the distinction between these stages of deficiency is not always definite, and anatomic lesions are probably invariably accompanied by chemical, physiologic or functional changes, none the less this concept is of great value in understanding degrees of nutritional deficiency and the exceedingly rapid or slow response of deficiency states to treatment. Biochemical lesions and functional changes may very rapidly be reversed, following treatment, while anatomic changes are only slowly or incompletely reversed.

Deficiency states of *marked degree* depend on definite and usually extensive pathologic changes in the tissues, and they are usually represented by well-recognized clinical conditions, such as beri beri, pellagra, rickets, scurvy, and nutritional edema.

In a second group may be placed those conditions which usually are due to a deficiency of *moderate degree*, such as the peripheral neuritis of alcoholism, nutritional night blindness, certain types of macrocytic anemia, and glossitis. In these cases the deficiency is less marked than it is in those of the preceding group, and the symptoms depend on physiologic and pathologic changes of a less extensive degree.

In a third group may be placed those conditions in which the nutritional deficiency is of *mild degree*, and in which the deficiency state depends principally upon physiologic and chemical abnormalities, and perhaps upon slight anatomic changes in the tissues. In this group of cases the clinical manifestations usually are less specific than those of the other groups, or are nonspecific, and, as will be pointed out subsequently, represent the principal diagnostic problem in the clinical phase of nutritional deficiency.

RECOGNITION OF EARLY NUTRITIONAL DEFICIENCY

Because the essential nutrients probably are necessary for the function of all tissues and organs, diseases produced by deficiency of them may lead to a large variety of lesions and symptoms. This is clearly indicated if a tabulation is made of the lesions resulting from deficiency of the vitamins (Table 3). However, our concern in this discussion is not with well-balanced and fairly easily recognizable conditions of nutritional deficiency, but with the early signs and symptoms which may accompany deficiency of them. These early general symptoms and signs are usually vague and indefinite, although at times symptoms which are characteristically those of a deficiency of a single vitamin or other nutrient may appear to be the initial and outstanding ones early in the course of the disease.

TABLE 1.—*Vitamin Intake Effect on Health and Tissues*

VITAMIN INTAKE Level of Requirement	STATE OF HEALTH	TISSUE CHANGES
Optimal	Buoyant	Tissue Saturation
Minimal	Passable	Tissue Depletion
		Biochemical Lesion
Deficient	Deficiency Disease	Functional Changes
		Anatomic Lesions

A sense of fatigue or lack of energy, inefficiency and mental irritability, mild anemia, simple disorders of the digestive tract, and symptoms and signs referable to faulty growth, to the nervous, blood-forming, and reproductive systems, and to the skin, have been considered by Minot as early general symptoms of nutritional deficiency states. More recently, a subcommittee of the National Research Council has listed the signs and symptoms definitely suggestive of such conditions. (Table 4).

It cannot be too strongly emphasized that these early symptoms and signs are not specific for nutritional deficiency, as they occur also in the early stages of many other diseases. The reason for the vague and nonspecific nature of these symptoms can well be appreciated when one considers that, in the early stages of nutritional deficiency, the lesion produced may not only be a biochemical or physiologic one, with slight if any anatomic changes, but it may be widespread and not produce characteristic specific dysfunction of a single organ or tissue in the body.

TABLE 2.—*The Character of Nutritional Deficiency States*

Degree of Deficiency	*Clinical Signs*	*Essential Changes*	*Incidence*	*Diagnosis*
Marked	Classical deficiency disease	Extensive pathologic	Rare	Clinical findings
Moderate	Variable Definite	Pathologic and Physiologic	Occasional	Clinical findings Laboratory tests
Mild	Non-specific or absent (Preclinical?)	Physiologic Chemical	Common	Laboratory and Therapeutic tests

It is obvious that a diagnosis of a nurtitional deficiency state cannot be made alone on the basis of the symptoms noted in Table 4; in fact little more than a suspicion of the condition can be stimulated by the presence of them. The next logical steps in establishing the diagnosis include a search for symptoms which are specifically those of deficiency of one or more of the vitamins or other substances, and to secure information in regard to adequacy of the previous diet, the function of the gastrointestinal tract, the use of alcohol, and evidence suggesting the occurrence of an infection, of pregnancy, or of hyperthyroidism. Naturally, the physician will make every effort to eliminate other causes for the symptoms, particularly nervous exhaustion, psychoneurosis, tuberculosis, rheumatic conditions, and other functional and organic diseases.

What more specific means than the evaluation of these clinical factors can be useful in establishing the diagnosis of an early nutritional deficiency? In general there are two. The first has to do with chemical determinations of the values for vitamins or other nutrients in the body fluids and tissues, of tolerance tests and of biologic tests, such as the biophotometer test. The second has to do with a therapeutic test consisting of administration of an optimal diet, or of one or more of the various food factors, and observation of the effect of them on the symptoms or signs suspected of being the result of a deficiency state. By some experts an analysis of the previous diet, the dietary history, of the patient has been used as an index of nutritional deficiency. An accurate dietary history is very difficult to obtain, usually requires a skilled social worker, is expensive and consumes a good deal of time, and is therefore not practicable for the average physician.

TABLE 3.—*Lesions Observed in Vitamin Deficiencies (Modified after Haden)*

Nervous System:
- Peripheral neuritis: paresthesias, pain, weakness, paralysis.
- Cerebral: mental disturbances, psychosis, psychoneurotic manifestations.
- Degeneration of spinal cord: chiefly lateral and/or posterior column.
- Disturbance in function: tetany.

Alimentary Tract.
- Symptoms: Anorexia.
- Secretory disturbances: achlorhydria, loss of specific ferments.
- Motor disturbances: diarrhea, loss of tone and motility.
- Pathologic changes in tissues: stomatitis, glossitis, strophy of tongue, ulceration of intestine.

Cardiovascular System.
- Nutritional heart disease.
- Edema.
- Easy bruising: Hemorrhage.

Skin and Other Epithelial Tissues.
- Scaling, keratinization, dermatitis, strophy, pigmentation, ulceration.

Hematopoietic System.
- Macrocytic, hypochromic, microcytic anemia.

Eye.
- Disturbance in function—night blindness.

The simplest and best therapeutic test in the diagnosis of a nutritional deficiency is the administration of an adequate diet. Many patients with the symptoms previously noted will show striking improvement in health as well as disappearance of symptoms when an adequate diet is made available and followed. Such an adequate diet is patterned on the Recommended Daily Allowances for Specific Nutrients. (See Table 1, Article by Hardgrove, Grace, on page 287.)

Occasionally it may be desirable, especially when signs of specific deficiency are present, to supplement such a diet with concentrates or synthetic preparations of the vitamins. Vitamin A in doses of 25,000 to 100,000 U.S.P. units, as fish oil, components of the Vitamin B complex, as wheat germ or powdered brewers' yeast in doses of 25 to 50 gm., ascorbic acid in large amounts of citrus fruit juices or in doses of 200 to 1000 mg., generally should produce a rapid therapeutic response in patients whose symptoms are due to deficiency of vitamins. In so far as possible, it is well to avoid the continued use of such substances for periods beyond one month; for if relief of symptoms has not occurred in that time, it is highly unlikely that they are due to deficiency of vitamins. The parenteral use of preparations of vitamins in patients of this type is rarely necessary and generally is needed only when there are gastrointestinal disturbances of considerable degree, and for purposes of the psychic effect of an injection treatment. In an occasional case only are the substances effective when parenterally administered to patients whose symptoms are refractory to oral medication.

In measuring the effectiveness of a therapeutic test, consideration must be given to psychologic factors in evaluating a good response. Consultation with a physician, acceptance of treatment and administration of pills, capsules or injections of vitamins, have produced cures of many conditions other than those resulting from nutritional deficiency.

For purposes of completeness a brief review of the early signs and symptoms of certain specific vitamin deficiencies will now be considered.

TABLE 4.—*Symptoms and Signs Which May Be Suggestive of Early Deficiency States*[1]

(1) General
- (a) Loss of weight
- (b) Loss of strength

(2) Oral
- (a) Sores at angle of mouth (cheilosis)
- (b) Stomatitis
- (c) Glossitis—red tongue
- (d) Red swollen lingual papillae
- (e) Papillary atrophy of tongue
- (f) History of sore tongue or mouth
- (g) Sore and bleeding gums
- (h) Serious dental abnormalities
- (i) Vincent's angina

(3) Gastro—Intestinal Trace
- (a) Lack of appetite
- (b) Chronic diarrhea
- (c) Failure to eat adequate breakfast

(4) Nervous System
- (a) Aversion to normal play
- (b) Poor sleeping habits
- (c) Backwardness in school
- (d) Lassitude and chronic fatigue
- (e) Lack of mental application
- (f) Nervousness and irritability
- (g) Paresthesias
- (h) Loss of vibratory sensation
- (i) Increase or decrease of tendon reflexes
- (j) Hyperesthesias of skin

(5) Skeletal
- (a) Poor muscle tone
- (b) Bad posture
- (c) Square head, wrists enlarged, rib beading
- (d) Muscle and joint pains, muscle cramps
- (e) Muscle tenderness, extremities

(6) Poor development
- (a) Failure to gain steadily in weight
- (b) Late period of sitting, standing, and walking
- (c) Inability to sit
- (d) Pain on standing and sitting

(7) Skin
- (a) Lack of subcutaneous fat
- (b) Wrinkling of skin on light stroking
- (c) Rough skin (toad skin)
- (d) Nasal blackheads and whiteheads
- (e) Nasolabial sebaceous plugs
- (f) Bilateral symmetrical dermatitis
- (g) Purpura
- (h) Dermatitis, facial butterfly, Casal's necklace, perianal, scrotal vulval

(8) Respiratory
- (a) Repeated respiratory infections

(9) Blood
- (a) Pallor
- (b) Hemorrhage of newborn
- (c) Tendency to bleed

(10) Cardiovascular
- (a) Rapid heart
- (b) Edema

(11) Eyes
- (a) Night blindness
- (b) Photophobia
- (c) Burning and itching of eyes
- (d) Lacrimation

[1] Modified from a report of a subcommittee of the Subcommittee on Medical Nutrition of the National Research Council. T. T. Mackie, M.D., Chairman, May, 1941.

EARLY SIGNS AND SYMPTOMS OF SPECIFIC VITAMIN DEFICIENCIES—DEFICIENCY OF VITAMIN A

Clinical.—The most readily-appreciated symptoms of Vitamin A deficiency have to do with changes in the eyes. In conditions of mild deficiency, these symptoms consist principally of night blindness or inability to see clearly in dusky light, and of conjunctival irritation or lesions. A history of photophobia, blepharitis or dryness of the eyes may be indicative of the condition, and on gross inspection of the eyes there may be no changes or slight pigmentation, unusual dryness or a granular appearance of the conjunctivae. Abnormal dryness or scaling of the skin may be an early manifestation of Vitamin A deficiency and, subsequently, in more marked degrees of deficiency there develops a red papular eruption resembling goose flesh, or a horny type of eruption involving the skin principally of the extensor surfaces of the arms and thighs.

Laboratory or Objective Diagnostic Procedures.—For patients in whom one suspects the possibility of Vitamin A deficiency the following objective methods are available to aid in establishing the diagnosis: (1) determination of the Vitamin A or carotene content of the blood plasma; (2) measurement of alterations in dark adaptation by the biophotometer method, and (3) response of the patient to treatment with Vitamin A.

No one of these methods is entirely satisfactory from the standpoint of the general practitioner, because the use of the biophotometer is limited to practitioners in a large city and the diagnostic value of it is still in dispute. Estimations of the Vitamin A and carotene content of the blood plasma are procedures limited to experimental laboratories, and the value of such calculations as a means of establishing a deficiency of Vitamin A has not yet been clearly established.

Therapeutic Test.—A therapeutic test of 25,000 to 75,000 USP units of Vitamin A daily for a week or two should produce a prompt decrease in the early symptoms and signs of Vitamin A deficiency. Definitely established skin lesions may require more prolonged therapy.

Such a therapeutic test constitutes the simplest objective procedure in making the clinical diagnosis of Vitamin A deficiency; and while a positive result does not prove the diagnosis, none the less it is highly indicative of it.

DEFICIENCY OF THIAMIN

Clinical.—The early symptoms of thiamin deficiency have relation to the nervous system, and particularly to the nervous and psychic response of the patient. Indeed, the early symptoms have much in common with those of neurasthenia or psychasthenia, and include irritability, depression, weakness, quarrelsomeness, sore muscles, lack of coöperation, fear, anxiety, insomnia, and loss of weight. Subsequently the more common symptoms of peripheral neuritis including pain, paresthesias and weakness develop in the extremities. Anorexia is commonly present.

Laboratory and Objective Procedures—Methods available include (1) determination of the thiamin content of the previous diet of the patient and comparison of it with the normal values; (2) determination of the thiamin values of the blood and urine; (3) determination of the pyruric and lactic acid values of the blood; (4) excretions of thiamin in the urine after a test dose of it, and (5) a therapeutic test. Recent studies by Williams, Wilder and associates indicate that the earliest stages of thiamin deficiency may be demonstrated by the determination of excretion of thiamine hydrochloride after administration of a test dose of it. In general these procedures, with the exception of a therapeutic test, are restricted to laboratories or clinics in which such studies and determinations can be made.

Therapeutic Test.—For the average physician the diagnosis of thiamin deficiency still depends on clinical phenomena and relief of them, following a therapeutic test with substances containing the vitamin. Administration of thiamine hydrochloride in 10 mg. doses several times daily, orally or parenterally, should, in the course of a few days to two weeks, result in prompt improvement or disappearance of nervous symptoms presumably due to thiamin deficiency.

Since deficiencies of the components of the Vitamin B complex almost always coëxist, the most satisfactory therapeutic test for them consists of administration of brewers' yeast in doses of 30 to 50 gm. daily, for one to two weeks, or of a concentrate of the complex in comparable doses parenterally if the gastrointestinal tract is not functioning normally.

DEFICIENCY OF RIBOFLAVIN

Clinical.—It is early stages ariboflavinosis may be manifested by (1) ocular symptoms consisting of photophobia, burning of the eyes, lacrimation and slight injection of the margins of the cornea; (2) oral lesions with linear fissures, redness and soreness of the corners of the mouth, and slight flattening of the papillæ of the skin, and (3) dermal lesions with seborrhoeis accumulations in the nasolobial folds and around the eyelids or ears.

Laboratory and Objective Procedures.—Such procedures are of questionable value. Determinations of the riboflavin content of the blood or urine can be made, but are restricted to specialized laboratories, and the interpretations of the results of them are still in the experimental stages. Examination of the cornea with the slit lamp, and discovery of loops or capillaries invading the cornea from the periphery, are considered by some investigators a useful means of detecting riboflavin deficiency in its early stages. If this abnormal vascularity disappears rapidly after treatment with riboflavin, the test is considered diagnostic. However, the diagnostic usefulness of the slit-lamp examinations is not universally accepted.

Therapeutic Test.—A therapeutic test with riboflavin, in doses of 5 to 10 mg. administered several times daily for a period of one to two weeks, with rapid clearing of the above noted symptoms, would constitute reasonably good evidence of previous riboflavin deficiency. As in the case of thiamin deficiency, a more satisfactory therapeutic test in ordinary conditions of practice consists of the administration of brewers' yeast as previously noted.

DEFICIENCY OF NIACIN

Clinical.—The early symptoms of pellagra, which is in large part due to deficiency of niacin and the components of Vitamin B complex, may be largely nervous in type and consist of restlessness, nervousness, insomnia, lassitude, irritability, easy fatigue, vague aches and pains, lack of energy, a tendency to excessive worry and similar symptoms frequently observed in patients with nervous exhaustion and other functional disorders of the nervous system. Associated with this there may be slight anorexia, glossitis with burning, redness and edema of the tongue, possibly slight diarrhea, and a mild dermatitis, suggesting sunburn and affecting principally the exposed surfaces of the backs of the hands, wrists, forearms, and face, usually in symmetrical fashion.

Laboratory and Diagnostic Procedures.—Unfortunately to date there has not been developed a satisfactory laboratory method for detecting niacin deficiency.

Therapeutic Test.—Administration of niacin and niacin amide in doses of 10 mg. six or eight times daily, for one to two weeks, or of powdered brewers' yeast in doses of 20 to 30 gm. three times daily for a similar period,

should cause rapid regression and almost if not complete disappearance of the symptoms of niacin deficiency.

DEFICIENCIES OF PYRIDOXIN (VITAMIN B_6) PANTOTHENIC ACID, CHOLINE, BIOTIN, INOSITOL AND PARA-AMINOBENZOIC ACID

No specific symptoms in man have been established as characteristic of deficiency of these substances.

DEFICIENCY OF ASCORBIC ACID (VITAMIN C)

Clinical.—The most readily appreciable symptoms of ascorbic acid deficiency have to do with hemorrhagic phenomena, particularly small hemorrhages into subcutaneous, subperiosteal, gingival and other tissues. Delay in healing of wounds, sponginess and slight swelling of the gums, anemia, and fleeting pains in the extremities have been ascribed to slight deficiency of this vitamin, and are said to be characteristic of early deficiency of it.

Laboratory and Objective Procedures.—Methods available include (1) analysis of the Vitamin C content of blood and urine; (2) excretion tests of the vitamin following administration of test doses; (3) roentgenologic studies of bones, revealing changes in the ends of the bones characteristic of scurvy, and at times subperiosteal hemorrhage, and perhaps (4) capillary fragility and resistance tests. The normal range for Vitamin C in the blood plasma in adults is from 0.7 to 1.3 mg. per 100 c.c. Values above 1.0 mg. per 100 c.c. if confirmed probably would eliminate the possibility of ascorbic acid deficiency, while values below this level and, in fact, below 0.7 mg. per 100 c.c., would not necessarily confirm the diagnosis of a deficiency. Excretion tests, or administration of test doses and studies of elimination of them, have value principally for those interested in research.

Therapeutic Test.—Administration of orange juice in large amounts, or of Vitamin C in test doses of 200 to 1000 mg. daily in divided doses, should produce rapid disappearance of symptoms if they are due to deficiency of the vitamin.

DEFICIENCY OF VITAMIN K

Clinical.—Hemorrhagic phenomena in patients with hepatic disease, jaundice, striking gastrointestinal abnormalities and in newborn infants, suggest the likelihood of Vitamin K deficiency.

Laboratory and Objective Procedures—Numerous laboratory and bedside methods for determination of the so-called "prothrombin time" have been developed and are extremely useful in detecting deficiency of Vitamin K before it manifests itself clinically by hemorrhage, and in establishing the diagnosis, once bleeding has occurred.

Therapeutic Test.—Administration of one of the numerous preparations of Vitamin K, such as menadione, in doses of 1 to 2 mg. parenterally or orally twice daily for several doses generally, is a very effective therapeutic measure, as well as a test of deficiency of the vitamin.

DISCUSSION AND SUMMARY

To the average physician the most puzzling aspects of this problem are the lack of specificity of signs and symptoms of early nutritional failure, and the lack of simple specific objective tests to establish a diagnosis. Furthermore, there is difficulty in the proper evaluation of the relationship or lack of it between previous diet, symptoms or signs of early nutritional deficiency, and studies of the chemical values for vitamins in the blood and urine. It seems clearly established that there is not any correlation between these three factors.

Vague and nonspecific symptoms, such as fatigue, lack of energy, inefficiency, irritability, nervousness, anorexia, slight weight loss, insomnia, restlessness, and vague aches are common in early nutritional failure; but they occur also in a host of other functional and organic diseases.

For the practical purposes of the average practitioner of medicine the most satisfactory methods of settling the possibility that symptoms are the result of nutritional deficiency, are, first, to rule out other causes for them by a carefully-evaluated history and examination; second, by study of the previous diet of the patient, and, finally, by administration of an adequate diet, meeting the recommended daily allowances established by the Food and Nutrition Board of the National Research Council, with or without supplements of vitamins in concentrates and synthetic form, over a period of two to four weeks.

In only occasional cases will it be necessary to continue specific therapy over a longer period of time to establish evidence of a previous dietary deficiency, and only rarely will it be necessary to resort to parenteral administration of the vitamins as a test measure.

Disappearance of symptoms, following such a therapeutic test, is a happy outcome. It indicates, but does not establish or prove a previous dietary deficiency. The results must be tempered with clinical judgment of psychogenic factors which may play a significant rôle in alleviating nonspecific and general symptoms.

To sum up, physicians must still use their clinical judgment in recognizing the early stages of vitamin deficiency, and, in making a diagnosis, must depend chiefly on an evaluation of the vitamin content of the previous diet of the patient, on the presence of signs and symptoms suggestive of deficiency disease, and on disappearance of these findings following use of an adequate diet and administration, for a limited period of time, of therapeutic doses of the vitamins.

237 Fourteenth Avenue.

THE PRACTICAL USE OF VITAMINS IN WARTIME*

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Los Angeles

THOUGHTLESSLY, the busy practitioner may commit either one of two errors: (1) totally ignore the importance of vitamins in nutrition, or (2) indiscriminately advise or condone the use of unnecessary commercial preparations. Either fault would dodge one of our real responsibilities; for we, as physicians, have the great responsibility of putting our patients and their families straight on this whole vital problem of nutrition. They look to us to be the final referee in all matters of health. No longer can we pass off this subject of nutrition with a shrug, nor fall back on the old admonition, "Let your appetite be your guide."

They must be told:

That adequate nutrition is the primary basis for optimal growth, development, and general good health.

That vitamins are real, tangible, essential chemical substances—not mysterious ghosts, nor merely subjects for a good joke.

That they are required as catalysts or accelerators to make available our building and energy foods, proteins, carbohydrates and fats, for the creation and maintenance of normal tissue structure and function.

That Nature has provided them as components of our normal natural foods.

That they are not all present in all foods; therefore, the need for a properly selected, "balanced" diet.

That they may be lost, all or in part by over-refinement, by improper cooking, heating and preserving.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Department of Clinical Medicine, University of Southern California School of Medicine.

That vitamins, by themselves, are not foods, and that by no stretch of the imagination can they replace proteins, carbohydrates, fats, adequate calories nor minerals.

That no vitamins will relieve fatigue, restore "pep," nor prevent infection when these conditions are due to causes other than vitamin deficiency.

PRESCRIPTION OF VITAMINS

The prescription of vitamins, as such, is usually considered from two points of view: (1) that of their curative properties, when actual signs and symptoms of deficiency already exist, and (2) that of their protective value, when there is reason to suspect that the diet is inadequate and can not be corrected.

Today, more than ever, should each patient have a nutritional survey as part of any medical examination. This should include a search for physical or functional evidence of vitamin and other deficiencies—(see article by Dr. Wilbur in this series). Should such evidence be demonstrated, then appropriate concentrates of specific vitamins should be given in adequate dosage to effect a cure. It is important to remember that, in the treatment of vitamin deficiency disease, best results are obtained when full reliance is not placed on synthetics or concentrates alone, but when these are combined with a fully adequate vitamin-rich diet of carefully selected and prepared food. It is also important to remember that, in general, single deficiencies seldom occur. One may be dominant, but if the background is such as to encourage one deficiency, others are apt to be present in greater or less degree.

Evidence of deficiency, clinical or "subclinical," may be present because the subject has habitually followed an inadequate diet due to ignorance, careless choice, faddism, poverty, prescribed "diets" or perhaps because he has been more or less entirely dependent upon restaurant food. In these busy days, people tell us that they do not have time to market and to prepare food properly, or that eating facilities at or near their place of employment are entirely inadequate. Perhaps patients have not learned to adjust their eating habits properly to the restrictions of rationing.

Aside from the special wartime problems of today, the physician must continue to be alert to the effects of chronic disease on the nutritional status of his patients. The "clinical picture" of chronic, prolonged, gastrointestinal disease, chronic heart failure, long-continued infections, as well as chronic alcoholism and mental disorders, may be due in considerable part to various nutritional deficiencies. Certainly for these patients, supplementary vitamins are indicated. They should be selected to relieve the deficiency which is present, and should be given in adequate dosage.

Before advising the use of vitamin supplements by the worker and others able to ingest and digest adequate quantities of food, one should always make every effort to determine dietary habits and, if indicated, make emphatic the need for a proper food program. If the patient is not regularly consuming adequate quantities of each of the "Basic Seven Foods," it is hardly probable that he is following a fully adequate food program. Not only are the chances good that his vitamin intake is below standard, but that other essential elements are also lacking or present in insufficient quantity.

STANDARDS OF THE FOOD AND NUTRITION BOARD OF NATIONAL RESEARCH COUNCIL

When attempts are made to meet the minimum standards recommended by the Food and Nutrition Board of the National Research Council, it is apparent that most difficulty is encountered in regard to fully-adequate amounts of the B complex and especially thiamin. In general, in California, because of the availability of citrus fruits and green vegetables, it is relatively easy to suggest a food program containing generous amounts of Vitamins A and C: 3½ oz. of green vegetable, or 3½ oz. of carrots, or 4 oz. liver, or 3½ oz. Hubbard squash will each provide over 6000 units of Vitamin A or its precursor carotene. One-half grapefruit, or one orange will supply over 75 mg. ascorbic acid (C), in addition to that derived from other fruits and vegetables such as cabbage, tomato and musk melon. In spite of generous amounts of sunshine on this coast, most infants and young growing children, as well as pregnant women, should have supplementary vitamin D, as available in fish-liver oils or their concentrates. Thought should also be given those persons who work night shifts or are otherwise kept too much out of the sun. It is probably wise to protect these people with approximately 400 international units of a potent supplement per day.

To return to the B complex: numerous surveys by competent investigators have demonstrated that, as a people, we are most likely to be deficient in this group. The increased use of refined carbohydrate food, such as highly-milled white flour and sugar has encouraged a general deficiency in two ways; (1) by lowering the intake of B from natural sources and (2) by increasing the requirements. It is to be remembered that the higher the carbohydrate content of the diet and the higher the total caloric intake, the greater are the requirements for the B group vitamins. This is especially true in relation to thiamin (B_1). As emphasized by Mrs. Hardgrove, the diet must be carefully selected and carefully prepared, so as to avoid losses through storing and cooking in order to meet the minimum standards for daily thiamin (and other components of the B group) intake.

The normal requirement of thiamin appears to be proportioned to the total metabolism or total food intake, rather than to the body weight. Thus the child requires more in proportion to its size than the adult. Vigorous physical activity or over-feeding increases the thiamin requirement. It is also affected by the relationship between fat and nonfat calories in the diet, increase in the proportion of fat decreasing the need for Vitamin B_1. In hot weather there should be an extra provision for this vitamin in the diet. The greater the gastro-intestinal wastage, the greater must be the thiamin intake. Infections, fevers, and other processes which stimulate oxidation correspondingly increase the vitamin requirement.

The literature of the past few years has been inclined to stress particularly the wide-spread inadequacy of thiamin in the average diet. Consequently, there has perhaps been too great a tendency to advise the use of this separate entity (usually synthetic) to the neglect of other members of the complex. Also it must not be forgotten that there is evidence that there are components of the B complex that so far have not been positively identified. There is evidence, too, that when the whole complex is taken in quanitatively normal or natural proportions, better results can be expected. Consequently, when the daily diet can not be made adequate or, for therapeutic reasons, it seems advisable to prescribe supplements, it is best and cheapest to use a natural source, such as brewers' yeast, wheat germ or rice polishings, when this can be done. One ounce of a good strain of brewers' yeast will provide approximately 1.6 milligrams Thiamin, 1.1 milligrams Riboflavin and 11.4 milligrams Niacin and, in addition, other valuable components of the B group.

It has been pretty definitely proven that increasing the intake of vitamins above quantities normally needed will not increase efficiency, endurance, nor strength. If physical inefficiency is due to vitamin lack, then supplementary sources of these substances will improve the situation.

IN CONCLUSION

The above paragraphs have been written with the belief that the private physician should concern himself with the nutritional status of each patient, and thereby indirectly with that of the family. There can be no disagreement with the point of view that good nutrition is the basis for good health, and that food, properly selected and prepared, is far superior to pills and capsules. On the other hand, he must be alert to evidences of vitamin deficiency, and if found, treat them adequately.

There is another aspect of the problem that concerns those who are dealing with large groups of individuals under wartime pressure, such as thousands currently engaged in the war industries. Impatient with the slow processes and effectiveness of education, and the delays and handicaps encountered in establishing adequate feeding facilities in industry, many of these workers feel that time will be saved, efficiency increased and absenteeism reduced, if each worker is supplied daily with vitamin supplements. So long as such a measure is recognized purely as a stop-gap procedure, and the worker is not persuaded by example that this will solve his nutritional problems, this point of view is possibly justified.

1930 Wilshire Boulevard.

A COÖPERATIVE ENDEAVOR TOWARD NUTRITION IN INDUSTRY*

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San Francisco

NUTRITION in Industry is not just a simple problem of nutrition, as it is generally understood. It is more complex because it takes in more than the nutrition and malnutrition of individuals, and the adequate feeding of these individuals with the proper constituents of a balanced diet. It includes in addition:

1. The question of getting food to aggregations of workers.

2. The complications arising because of the various federal agencies with different points of view . . . e.g. The Manpower Commission requires a maximal number of workers healthy and on the job a maximal number of hours; the Maritime Commission has the production goal to accomplish, and thus approaches the question from that standpoint; while the Food Distribution Administration, Nutrition in Industry Division takes as its goal adequate in-plant feeding, with proper facilities and accommodations to do the job.

3. The Concessionaire approaches the problem from the standpoint of availability of food, the allotment of ration points, and the adequacy of facilities and manpower to carry out the feeding project.

Faced with this complex problem, the first necessary move of the Bay Area Nutrition in Industry was that of acquiring funds for a coöperative and coördinated organization for the industries in the Bay Area. Realizing that tuberculosis and nutrition were closely-related problems, the Tuberculosis Associations of San Francisco, Alameda, San Mateo, Marin, and Contra Costa Counties agreed to finance the project for the present year. Representatives from these associations and from the five county Nutrition Councils, constitute the Executive Committee. The actual Working Committee of this organization, which meets weekly to formulate new plans and discuss latest developments, is comprised of Herbert C. Moffitt, M.D., Chairman; W. Palmer Lucas, M.D., Acting Chairman; Wm. C. Voorsanger, M.D., Secretary San Francisco Tuberculosis Association; Harold T. Castberg, M.D., Chief, Bureau of Industrial Hygiene of the State Board of Health; Miss Jane Sedgwick, Nutritionist, State Board of Health; Mr. William Broeg, Industrial Nutritionist, FDA; Merrill Kelly Bennett, Ph.D. of the Stanford Food Research Institute; with the two full-time paid nutritionists, Mrs. Filsinger, and her assistant, Mrs. Hanson.

NUTRITIONAL NEEDS OF WORKERS

Although the health and welfare of the worker is a definite contractural requirement of the managers of industry, the nutritional needs of the worker have not been sufficiently emphasized. At the Lockheed Aircraft Plant in Burbank, California, a nutritional study was made under the general direction of the Nutrition in Industry Division of the National Research Council. Dietary histories of the workers were collected by Dorothy Wiehl and reported in the October, 1942, *Millbank Quarterly.*

In this study, it was found that only 2 per cent of the diets included amounts recommended as the dietary pattern by the National Research Council, Committee of Food and Nutrition, for five essential food groups; 11 per cent had "marginal" diets or moderately below standard, while 87 per cent had diets which were unsatisfactory for one or more food-groups.

Similar studies were carried on by the Nutrition in Industry Committee of ths Alameda County Nutrition Council. A breakfast survey disclosed that 63.9 per cent of the breakfasts of workers in a San Francisco Bay Area war industry were poor or omitted entirely; 21.9 per cent were "marginal" or moderately below standard, and 14.2 per cent were inadequate. A survey of home-packed lunches carried to one of the major shipyards in the San Francisco Bay Area disclosed that 40 per cent of the lunches were adequate for heavy work; 25 per cent were adequate for light work; and 35 per cent were inadequate for either light or heavy labor.

The Bay Area Nutrition in Industry Committee has now functioned for over 14 months, and the major problems it has faced have been:

1. Acquiring the coöperation of the managers of industry in the realization of the nutrition problems of their workers and action in accomplishing the Committee's goal toward adequate in-plant feeding. This has been an up-hill pull, not because management does not believe in nutrition and adequate feeding facilities, but because their major goal is production.

2. The difficulty that management envisions in getting adequate food to the men at their places of work is often more imagined than real. Every situation that we have studied has had possibilities for successful in-plant feeding.

3. So far the most insurmountable problem has been the Maritime Commission, which furnishes most of the funds for extra facilities in the yards contracted by the Commission. The attitude of its members in this area has been that they are opposed to in-plant feeding. As a compromise for this, they are most interested in the lunch boxes brought from home, and are, at present, constructing markets where workers can buy food for home and lunch consumption. As has been indicated, box-lunches are satisfactory neither from the standpoint of the one who eats them, nor that of the concessionaire who sells what is put up.

The second (educational) objective of the Bay Area Nutrition in Industry Committee has been accomplished as follows:

1. *Walt Disney Posters.* A series of three Disney posters are entitled, "You Can't Breakfast Like a Bird and Work Like a Horse," "A Goofy Lunch Pulls Your Punch," and "There's Fightamins in Fruits and Vegetables." These posters are enlivened by Disney's famous

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Offices of the San Francisco Nutrition Council and Nutrition in Industry for the Bay Area.

movie characters who carry this vital message to the people of the United States. They were made possible by the financial coöperation of this Committee and the Nutrition in Industry Committee of Los Angeles.

2. *Nutrition Classes.* An attempt has been made to provide classes in all the housing projects adjacent to the shipyards. Meeting with the workers for informal discussion of their problems has been found far more effective than formal lecture-classes.

3. *"Kitchen Door Kanteen."* A food and nutrition column edited by this Committee is offered to any shipyard and industrial publication. We are now serving six such publications, and attempt to meet all requests which come to us from editors of shipyard publications, and from the workers in the Women's Council Meetings we attend. We attempt to personalize these columns to the various conditions of each yard, and thus to do away with stereoptyped material so frequently left unread. This column gives weekly menus worked out under the ration system for families of two, four, or even one person living alone, to say nothing of the groups of bachelors trying to get enough to eat on their point allotments per week; it includes extenders for meat and butter as well, Thanksgiving suggestions for 1943, and many lunch box suggestions, with innumerable other themes fitting to the moment and the problems.

4. *"Recipes and Suggestions for Wartime Feeding."** Industrial cafeteria managers have been supplied with this folder, in order to receive solutions for their feeding problems under the present rationing system. There has been a great demand for these booklets from other sources, also having wartime feeding problems to meet. Three hundred copies sent to San Mateo County have helped the restaurateurs to keep their establishments open at a time when a large number were planning to shut down.

5. *Wartime Feeding Centers:* as the markets have been developed at the various yards, the Bay Area Nutrition in Industry has proposed the development of Wartime Feeding Centers staffed with Red Cross Nutrition Aides trained in their counties to answer questions on rationing, food preparation, meal planning, and also to distribute recipes and general nutrition material. Our first such center is located in the heart of the Government Housing Project in Richmond, California, in close proximity to the great Kaiser Shipyards. This project was taken over by the Richmond Red Cross Nutrition Committee, under the leadership of Mrs. Mildred Barrows. Here throngs of industrial workers shop at a spot where the Nutrition Aides may bring nutrition information to housewives and industrial workers, at the time and place where they need it most.

6. *"California Victory Lunch Boxes."* This newest project is a threefold leaflet decorated in the national colors, carrying as a front design the map of California in the background with an industrial worker in the foreground. This leaflet carries lunch box suggestions and pointers helpful to any person packing a lunch, whether he be an industrial worker or a school child.

7. *Posters.* This committee has designed original posters to meet the requests and demands of industry.

Thus it is that, through the combined accomplishments of the Bay Area Nutrition in Industry and the local, State, and Federal agencies, this committee stands hopeful that, in the not too distant future, the industrial feeding program in this area will be met, and that hot, nutritious food will be served to every contributor to the second line of defense on the home-front.†

2245 Post Street.

* The O.P.A. has requested permission to print 55,000 of these for distribution throughout the five Pacific Region States.

† After 14 months of effective pioneering work, the Bay Area Nutrition in Industry Committee has dissolved. Partially financed by the San Francisco Tuberculosis Association, the committee engaged in a well-rounded program to solve and simplify many nutrition problems which the war brought to industry in California.

Mrs. Filsinger, who was lent to the B.A.N.I. Committee to serve as chief nutritionist and Executive Secretary, has now resumed her former position as Home Economist for the Pacific Gas and Electric Company. In the future she will be available, as a representative of the company, to contribute a similar service to industrial and commercial companies who do in-plant or employee feeding in the city and county of San Francisco.

Mrs. Filsinger has been appointed chairman of the committee on industrial nutrition by the San Francisco Nutrition Council, and has pledged support of the council for the continuance of the program.

THE SCHOOL LUNCH PROGRAM*

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THE importance of providing school lunches of good nutritive value is well recognized. Better health, development, attendance and scholarship have resulted from adequate feeding. Feeding needy school children, originally by private charity and later at public expense, has been an old European practice. The famous Oslo Breakfast consisted of black bread, a hunk of goat's cheese, a raw carrot, a glass of milk, and an apple. The rate of growth of children on this diet increased 118-140 per cent. This almost perfect ration required neither equipment nor service. Such phenomenal results suggest that good food can build almost anything.

Cheap or free school lunches have long been served in the United States as a convenience. Until the Depression, the feeding of undernourished children remained a private charity. The Depression presented us with an enormous biological problem, the protection of children, and through them the generations to come. An attempt was made to make the economic problems of the depressed 1930's solve each other—unemployment, the glut of agricultural products, and the undernourishment of children.

Some 65,000 unemployed people prepared and served to two million school children the surplus farm commodities. These were distributed to millions of underprivileged families, and to schools through the welfare agencies. Thus, through the Depression large numbers of underfed children received one good meal daily.

Though the motive was to avoid food waste and price depression, benefit accrued to the farmers, to the unemployed and to six million children. The plan met with apathy and opposition. We were willing to spend $100 a year on a child's education, but loath to add $15 more to insure his ability to learn, though teachers agree that adequately-fed children show better development and adjustment, make greater intellectual progress without conscious effort, and have fewer illnesses—a decrease in the cost of education. The physician knows, furthermore that (1) normal development requires adequate nutrition, (2) optimum nutrition produces maximum development, and (3) deficiencies during critical growth years may do irreparable damage to the individual and, through him, to the race.

Germany's policy of "selective starvation" of the next generation of nonGerman, European children, and mass deportation "birth control" guarantees a biological German victory, and Germany anticipates overrunning Europe with her superior children. It behooves us to give attention to what Hoelzel calls the "nutritional determination of history."

We are turning from diet standards sufficient to sustain life to optimum standards that mobilize full capacities. Such a dietary ideal for every child is consistent

* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

with a democratic society, but we fall short of providing every child with even a minimal diet, and, despite our high-living standards, one-third of our people lack protective foods to the level of mild deficiencies. Were the yardstick of optimum nutrition applied, few would qualify.

The far-reaching school lunch attacks the problem directly and can become a great vehicle for mass nutrition education. It feeds, while training the child and his parents.

The program grew rapidly, but it is still too young to survive unaided. As school lunches were given preference in the defense program, so the overall wartime food administrators still feel that school lunches are of long range strategic national importance.

THE SCHOOL LUNCH

The Government has contributed $5,000,000. Local groups must provide equipment, labor, supervision, and 40 per cent of the locally bought food.

The school lunch should:

1. Be served under good conditions.
2. Contain *enough* of the right foods.
3. Contain much of the day's essential nutrients.
4. Be adjusted to the nutritional, racial and religious needs of the child and complement the home diet.
5. Be a plate lunch, which improves quality, lessens cost, reduces labor, saves food, provides variety, broadens tastes and food balance.
6. Develop good eating habits.
7. Be a part of health education.

Nutrition is a vital part of health education, and the school lunch should bridge the gap between theory and practice. Good food habits are not instinctive in man, but are wholly a matter of education. Man welcomes science in animal feeding, but resents it at his own table.

Some people see in this program undesirable social trends, but they fail to see the full significance of the degradation of our food which has taken place simultaneously with, and in part as a consequence of great scientific and industrial advances. They are sceptical of the seriousness of child malnutrition, because they do not realize that these advances have stripped our abundant and alluring foods of many of their vital qualities.

The physician must play a responsible rôle in the program because:

1. The science of nutrition promises a higher national health.
2. The doctor is the health consultant.
3. The physician must help set feeding standards.
4. The physician must weigh results.
5. The physician must select and certify children for special feeding.
6. The physician is held responsible for the health of the nation's children, and the quality of the generations to come.

The physician should, therefore, play a prominent rôle in the groups concerned with a community nutrition.

SUMMARY

The School Lunch Program has passed through the stages of private and public charity, and is now a public responsibility. The malnutrition of millions of children during the Depression emphasized the need of protecting a great national resource, shown by our newer knowledge of nutrition, to be in jeopardy.

Such feeding developed in the United States as an agricultural and unemployment relief policy, but has become a part of health education in the schools. It attacks malnutrition directly, while removing ignorance as an underlying cause.

Though the wartime food program has extended to all the people of the United Nations, and to the revamping of world agriculture, the problem of feeding American children continues to be of prime importance. Congress has appropriated $5,000,000, to insure to all children one good meal a day, despite poverty, ignorance and indifference, and despite food shortages, rationing and family dislocation.

722 Funston Avenue.

THE LITERATURE OF THE WARTIME NUTRITION MOVEMENT*

RUTH OKEY, Ph.D.
Berkeley

SOME review of the origins of our war-time literature in nutrition is essential to an appreciation of its values and limitations. The first large impetus was given to a program for better nutrition in America with the President's call for a national nutrition conference in May of 1941. This conference adopted the "Recommended Daily Allowances" for basic nutrients [I (1)] of the National Research Council as a working "yardstick" for measuring the adequacy of American diets. It also planned a program designed to make possible for every American a diet which would measure up to this standard.

To carry out this plan State and county nutrition committees had already been organized and a nutrition service had become part of the Office of Defense Health and Welfare Services. The Red Cross, the AWVS and many other agencies started nutrition classes, and one large grocery chain prepared a very good nontechnical correspondence course in nutrition.

The new nutrition program got under way with the slogan, "Eat the Right Food to Keep Fit" (I, 3) and we heard much about "buoyant health" in contrast to mere lack of illness. Food was plentiful in the United States in 1941, and nutrition programs were formulated on the basis that we would be able to have anything we needed and almost anything we wanted. Pressure was brought to bear on newspapers, magazines, the radio and, above all, on advertising firms, food producers, manufacturers, and distributors to make the public nutrition conscious.

Some of the best advertising talent and a large proportion of the food advertising budget was devoted to "contributions to the national nutrition program." Many of these made an honest effort at scientific accuracy, and were really formulated with the motive of service uppermost. The trained copy-writers, the gorgeous color photography, and the elaborate and interesting lay-outs of this commercial material put sadly in contrast the stilted phraseology, and the poor and unattractive printing of most of the scientific publications. Unfortunately, rigid adherence to fact seldom makes a story which can compete with that which admits of exercise of the imagination. Effective advertising has to tell a good story.

As the war has produced food shortages, and the emphasis in the nutrition program has had to be shifted from best choices from an abundance of foods to best use of the foods we have or can produce with a minimum cost for labor, the accuracy of our nutrition information has become more important. It didn't seem to matter so tremendously, two years ago, that a meat chart should be based on a protein allowance 10 grams above the NRC standard allowances, while figures for other nutrients held to the standard, or that the pictured serv-

* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Department of Home Economics, University of California, Berkeley Campus.

ing portions of meat were 20 grams larger than those of the other foods shown. Today, our point of view is altered. We can't afford the distortion of the picture which so many of our advertising agencies seem to feel their rightful "plug" for the product advertised.

Sorting the grain from the chaff has become an herculean task. The frank advertisements of food products which give tested recipes for their use and menus into which they fit, are probably our most valuable commercial circulars. Even these may need checking on the basis of retention of food values during preparation. It is definitely safer to confine one's recommendations to material known to have been checked by a reputable and noninterested agency, and it seems desirable to know what we can find in this category.

The following list is limited to some of the noncommercial publications which the writer believes may be most useful to the physician in California:

I. NATIONAL NUTRITION PROGRAM:

1. *Proceedings of the National Nutrition Conference of May, 9141.* Supt. of Documents, Washington, D.C. 35c.

2. *Food for a Stronger America.* Survey Graphic reprints. 1941. (Condensed report of the above.) 15c.

3. *Eat the Right Food to help keep you fit.* 1941 (see text) Supt. of Documents, Washington, D.C.

4. *Are We Well Fed?* Misc. Pub. U.S.D.A. ♯430. (Graphic condensation of the results of the dietary surveys by the Bureau of Labor Statistics and the Bureau of Home Economics. See text) Supt. of Documents, Washington, D.C. 15c.

5. *Hidden Hungers in a Land of Plenty,* National Maternal and Child Health Council. Obtainable from A.A.U.W. 1634 Eye Street N.W., Washington, D.C. 25c.

6. *This Problem of Food,* by Jennie Rowntree. Public Affairs. Committee, 30 Rockefeller Place, New York City.

7. *Planning for Total Food Needs* (of the country) by E. C. Vorhies, 1942. (One of a series of U. C. publications on Foods in Wartime. U. Calif. Press.) U. C. Press, Berkeley. 25c.

8. *Nutrition Reviews.* (Monthly periodical, each issue consists of 25 to 30 pages of brief and well-written reviews of new work in nutrition. Should be valuable to the physician.) Nutrition Foundation, Inc., Chrysler Building, New York, N. Y. $2.00 per yr.

9. *Inadequate Diets and Nutritional Deficiencies in the United States.* Bulletin of the National Research Council ♯109, November, 1943. Published by the National Research Council. Copies distributed by Mead, Johnson and Co., Evansville, Indiana.

II. WHAT CONSTITUTES A NORMAL DIET:

1. *Recommended Dietary Allowances,* National Research Council. Reprint and Circular Series ♯115. Jan. 1943 (see text) 2101 Constitution Avenue, Washington, D. C. (No charge)

2. *Planning Diets by the Yardstick of Good Nutrition:*
   (a) Low Cost (3 Market Orders)
   (b) Moderate Cost (1 Market Order)
   (c) Liberal Cost (1 Market Order)

Bureau of Human Nutrition and Home Economics. U.S. D.A. 1941. (Now available as separate sheets showing quantities of food required for one week. All were done before rationing. Supt. of Documents, Washington, D.C. $1.25 per hundred.

3. *Checking Food Values of the Daily Diet* by Hilda Faust, Home Demonstration Service. U. of Calif. 1943. (Nutritive values of foods in terms of common measures. Includes standards, and a form for recording and computing a day's food intake.) U. C. Press, Berkeley. 2½c per copy or $1.25 per 100.

III. ADJUSTMENTS TO RATIONING AND FOOD COSTS:

1. *Wartime Food for Four Income Levels,* by Ruth Okey and Edith J. Linford. Publication of the Heller Committee for Research in Social Economics, 1944. (Four sets of market orders for one week for families of four—adjusted to the income and needs of the executive, the white-collar worker, the skilled wage-earner doing manual work, and the family needing an adequate diet at minimum cost. All have been checked for nutritional adequacy. Menus are given for each and prices are included for San Francisco as of March, 1944. Ration adjustment to March, 1944. U. C. Press, Berkeley 35c.

2. See also material on individual foods—section V.

IV. THE MANAGEMENTS OF PATIENTS REQUIRING SPECIAL THERAPEUTIC DIETS:

Low Cost Special Diets. Parts II and III by a committee of the California State Dietetics Association, 1942 (Dietary plans, menus, and market order for most of the special diets likely to be required in the outpatient clinic. Made with low-cost foods likely to be available in wartime. Planned for use of doctors and dietitians only.) (Mimeographed copies on sale at ASUC store, U. C. campus, Berkeley).

V. PAMPHLETS DEALING WITH INDIVIDUAL FOODS AND THEIR USE IN THE WARTIME DIET:

1. *Series of leaflets.* U.S.D.A. Bureau of Human Nutrition and Home Economics, 1942 and 1943.
   a. Root Vegetables in Wartime Meals
   b. Green Vegetables in Low Cost Meals
   c. Dried Beans and Peas in Low Cost Meals
   d. Potatoes in Low Cost Meals
   e. Dried Fruits in Low Cost Meals
   f. Fats in Wartime Meals

(Discussion of the place of the food in the diet, special problems in its preparation, and recipes.) Each leaflet. Supt. of Documents, Washington, D.C. $1.00 per 100 copies.

2. *Soybeans for the Table.* Supt. of Documents, Washington, D. C. 5c each.

3. *Meat in Thrifty Meals.* U.S.D.A. Bulletin ♯1908, Supt. of Documents, Washington, D. C.

4. *Food Charts: Foods as Sources of the Dietary Essentials.* Prepared by a Joint Committee of the Council on Foods and Nutrition of the American Medical Association and the Nutrition Board of the National Research Council. Available as a 20 page pamphlet which reproduces charts and text showing contribution of nutrients by various foods. Distributed by Mead, Johnson and Co., Evansville, Indiana, without charge to physicians.

VI. CONSERVATION OF NUTRIENTS IN FOOD PREPARATION: VITAMINS:

1. *Saving Food Values II.* H. Faust and V. Greaves. Home Demonstration Service, U. Calif. (A review in outline form of the changes which occur in the nutrient values of foods during preparation, processing, and storage. Meant for the reader with some educational background.) U. C. Press, 3c each, $1.25 per hundred.

2. *Saving Food Values III.* H. Faust and V. Greaves, Home Demonstration Service, U. of C. (A simpler form of the above, illustrated and designed for use by the less well-trained housewife.) U. C. Press, 2c each, $1.00 per 100.

3. *Vitamin Values of Foods in Terms of Common Measure* (Tables of average only) prepared by U. S. Bur. Human Nutrition and Home Economics. Misc. Pub. ♯505, U.S.D.A., Supt. of Documents, Washington, D. C. 25c.

4. *Compilation of Detailed Results of Vitamin Assays of Food in Relation to Processing and Other Variants.* Booher, L. E., Hartzler, E. R. and Hewston, E. M. (Technical and not adapted to use by untrained persons.) U.S.D.A. Cir. ♯638. 244 pp. 1942. 25c.

VII. INDUSTRIAL NUTRITION:

1. *Food and Nutrition of Industrial Workers in Wartime.* National Research Council Circular Series 110. (First Report of Committee on State of Nutrition in Industry. Analysis of dietary deficiencies, practical considerations and recommendations.) Obtainable from National Research Council, 2101 Constitution Avenue, Washington, D. C.

2. *Planning Meals for Industrial Workers.* U.S.D.A. Food Distribution Administration Bulletin N.F.C.-2 June 1943. (Practical suggestion for feeding.)

VIII. CHILD NUTRITION AND THE SCHOOL LUNCH PROGRAM:

1. *The Road to Good Nutrition,* L. Roberts. Children's Bureau, U. S. Dept. Labor, Supt. of Documents, Washington, D. C. 15c.

2. *Food for Growth.* U.S.D.A. A.W.I.-1 (free).

3. *Building a Good Body.* 4 pp. by H. Faust, U. C. Press, Berkeley 2-49 copies 2c each, 100 or more 1c each.

4. *School Lunches.* 1940. Misc. Pub. ♯408 U.S.D.A. 10c.

5. *How to Feed Nursery School Children.* M. E. Sweeney and Dorothy C. Buck. Merrill-Palmer School.

6. *Well Nourished Children,* folder 14, Children's Bureau, U. S. Dept. Labor.

7. *Food for Children.* Farmer's Bulletin ♯1674. U.S.D.A. Supt. of Documents, Washington, D. C. 10c.

Department of Home Economics, U. of C., Berkeley.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

SPECIAL MEETING: C.M.A. HOUSE OF DELEGATES

Important. Attention of C.M.A. Members Is Called to Stiff Paper Red Ink Insert, Opposite Page 280 (Original Article Section).

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Eighty-fifth (185th) Meeting of the Executive Committee of the California Medical Association

An informal meeting of members of the C.M.A. Executive Committee resident in San Francisco, was held in San Francisco, on Monday, October 9, 1944, at 6:00 P.M.

By mail vote, the minutes which follow, and the actions taken, were approved by all members of the Executive Committee.

1. Roll Call:

Present: Drs. John W. Cline, Chairman; Philip K. Gilman, Council Chairman; Karl L. Schaupp, Past-President; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Councilor Lloyd E. Kindall of Oakland.

2. Proposed Alameda County Letter Regarding C.P.S.:

The purpose of the informal conference was to consider a letter of October 3, 1944, addressed to the Committee by Councilor Kindall, the same relating to an enclosure that was a preliminary and confidential draft of a letter concerning California Physicians' Service, in preparation by a limited number of members of the Alameda County Medical Association, the said letter to be mailed to all members of the California Medical Association.

Councilor Kindall stated that when the proposed letter came to his attention, he felt it was his obligation as a Councilor of the California Medical Association to call the same to the attention of the C.M.A. Executive Committee.

The nature of the letter and its possible effect concerning capacity of service by California Physicians' Service, were then considered in informal discussions.

Councilor Kindall stated he did not know how many signatures would be attached thereto, but he was under the impression there would be ten or more names.

The question was asked whether it would not be possible to have the group who were proposing to send out the letter appoint a sub-group that could meet with the San Francisco members of the C.M.A. Executive Committee to talk over the issues involved in an informal, round-table dinner conference, in hope of clearing up some of the issues upon which criticism was made. . . .

3. Woman's Auxiliary Publication, "The Courier":

Secretary Kress presented a letter dated September 23, 1944, received from Mrs. Ralph Eusden, President of the C.M.A. Woman's Auxiliary. Request was made therein

that the C.M.A. match the budget of the Woman's Auxiliary to make possible a larger edition of the Auxiliary publication, *"The Courier."*

This request was made because lack of space in CALIFORNIA AND WESTERN MEDICINE had made it impossible to continue publication of a Woman's Auxiliary department in CALIFORNIA AND WESTERN MEDICINE.

Secretary Kress stated that Executive Secretary Hunton calculated the cost of a page in CALIFORNIA AND WESTERN MEDICINE to be about $30.00 and that the Woman's Auxiliary had averaged one or two pages per issue in CALIFORNIA AND WESTERN MEDICINE, or $360.00 to $720.00 per year.

The request of Mrs. Eusden was that the C.M.A. match from C.M.A. funds, the Woman's Auxiliary budget of $375.00 for the publication of "The Courier," to permit a larger and more frequent publication. The San Francisco members of the Executive Committee felt this would be a proper procedure because the Woman's Auxiliary is no longer receiving space in CALIFORNIA AND WESTERN MEDICINE, and it was agreed that this recommendation should be made to the other members of the C.M.A. Executive Committee.

JOHN W. CLINE, M.D., *Chairman,*
GEORGE H. KRESS, M.D., *Secretary.*

Minutes of the One Hundred Eighty-sixth (186th) Meeting of the Executive Committee of the California Medical Association

An informal meeting of members of the C.M.A. Executive Committee resident in San Francisco, was held in San Francisco on Thursday, November 2, 1944, at 12:00 o'clock noon. These minutes were approved by mail vote.

1. **Roll Call:**

Present: Drs. John W. Cline, Chairman; Philip K. Gilman, Council Chairman; Karl L. Schaupp, Past-President; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Dr. T. Henshaw Kelly; Mr. John Hunton; Hartley F. Peart, Esq. and Howard Hassard, Esq.

2. **Letter which 21 members of the Alameda County Medical Society submitted for publication in "California and Western Medicine" containing statement in which they said they intended to send to all members of the California Medical Association.***

A letter dated October 17, 1944, sent to the Editor of CALIFORNIA AND WESTERN MEDICINE, by Dr. Sidney N. Parkinson of Oakland, with enclosure of a statement containing criticisms of California Physicians' Service by some 21 members of the Alameda County Medical Society was considered.

The statement referred to above had been previously submitted to members of the Council of the California Medical Association under date of October 23, 1944, by Council Chairman Gilman, whose attention had been called thereto by Councilor Lloyd Kindall. Chairman Gilman requested Councilors to submit suggestions in regard to future steps in procedure.

The Alameda statement was discussed from different angles. The San Francisco members of the Executive Committee agreed to recommend to the full membership of the Executive Committee as follows:

1. That the statement submitted by Dr. Parkinson on behalf of 21 members of the Alameda County Medical Society concerning C.P.S. be printed in the December issue of CALIFORNIA AND WESTERN MEDICINE, it being too late for appearance in the November issue because that number was in press.

2. That the Council at its meeting on December 3rd consider formulation of a draft in reply to the criticisms made by the 21 members of the Alameda County Medical Society, for possible appearance in CALIFORNIA AND WESTERN MEDICINE.

3. It was also voted that a special committee consisting of Legal Counselors Peart and Hassard, Executive Secretary Hunton and Secretary-Editor Kress be instructed to prepare drafts of replies, the same to be submitted to the Chairman of the C.M.A. Executive Committee for possible transmittal to members of the C.M.A. Council, for further suggestions as to content, form, etc.

4. Also, this committee to be instructed to draft replies to any new communications or procedures that might arise prior to the meeting of the C.M.A. Council of December 3rd, and to submit same to the Chairman of the Executive Committee for consideration and action.

3. **Adjournment:**

Upon motion made and seconded, it was voted to adjourn.

JOHN W. CLINE, M.D., *Chairman,*
GEORGE H. KRESS, M.D., *Secretary.*

CALIFORNIA PHYSICIANS' SERVICE*

Letters from Alameda County Medical Members; Reply Statement by C.M.A. Executive Committee; and other items in relation to prepayment plans for medical care.

I

Statement by 21 Alameda County Physicians

CALIFORNIA PHYSICIANS' SERVICE*

(Following statement by 21 Alameda County Doctors, was forwarded with request for publication in CALIFORNIA AND WESTERN MEDICINE. *Request was granted by the C.M.A. Executive Committee.)*

* * *

As a prelude to specific discussion of California Physicians' Servcie in its relationship to medical practice, it seems well to express a few generalizations. These generalizations probably are acceptable to a large proportion—we believe a majority—of Doctors of Medicine.

1. Freedom of Medicine is worth defending.

2. Freedom of Medicine consists of unimpaired doctor-patient relationship.

3. Medicine is more efficient, scientific, progressive, and economical when conducted as private enterprise.

4. Medicine must be defended from Socialization regardless of sponsor or avowed purpose.

5. Elements seeking Socialization of Medicine are aggressive and persistent. Our proper and effective response is intelligent defense, not apathy or collaboration.

6. The minimal requirement for preservation of Freedom of Medicine is open defense under responsible leadership.

7. Insurance, ably managed, can protect the patient by partial reimbursement without injury to Medicine.

C.P.S. was presented to the doctors of California as a plan to provide medical care for the so-called Low-Income-Group. Analysis revealed sufficient evidence to doubt the wisdom of the plan. Official State figures on income indicated that 91 per cent* of Californians were eligible. This proved that C.P.S. was not designed for any group but for virtually the entire population.

Would C.P.S. prevent State Medicine? There is not the slightest evidence that appeasement schemes discourage Socializers.

Is C.P.S. insurance? When Alameda County urged that C.P.S. be changed to insurance, which would protect the patient but in no way injure Medicine, we were told

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* For editorial, p. 279; other comment follows.

* Commonwealth, May 27, 1941, p. 430.

not only that C.P.S. is not insurance but that insurance was not intended. This is highly significant. Blue Cross and other hospitalization plans are true insurance. Hospital management insisted upon it. Insurance can apply to medical care too, if we insist upon it. Let C.P.S. be changed to insurance. It then would pay a specified sum for a specified service—but pay it to the patient. Let the doctor decide whether the sum is adequate compensation in each case. Nonprofit Insurance, ably managed, is likely of permanent success because it will be confidently patronized. This is evident from the success of the many plans now operated by private enterprise.

It is now perfectly clear that C.P.S. as at present constituted is identical in theory and purpose with Socialistic schemes such as the Children's Bureau Plan, the Wagner Bill, and the Kaiser Health Plan. The essential in all is release of the patient from financial obligation to the doctor. An *agency* controls both cost to patient and fee to doctor and thereby attains influence over both.

The development of C.P.S. coincided with a surge of Leftism throughout California. With a trend toward Conservatism it is possible that pressure for such schemes may subside. But even were we to take the pessimistic view that Socialization is inevitable, yet we ask "Why accept Socialization while we still have the right to reject it?". We can keep Alameda County Medicine free if we will to do so.

Too prominent among the advocates of C.P.S. are doctors least affected by it, particularly doctors on salary at public and private institutions. It is the doctor in everyday practice who must endure the red tape, petty annoyances, chiseling, reduced scientific interest, reduced freedom, and reduced income.

If it be said that Alameda County is almost alone in rejecting C.P.S. and preferring to retain the freedom of private practice, let it not go unsaid that California is almost alone in having a State Medical Association attempt to impose such a scheme on its members.

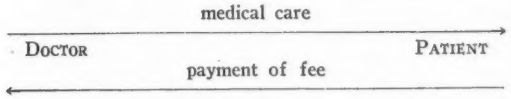
C.P.S. was rejected by Alameda County after investigation and experience sufficient to learn its nature and its workings. But C.M.A. officials continually press us to rescind our action and permit C.P.S. to again take hold in our community. Needless to say, we are determined to keep our County clean. We will continue to reject C.P.S. until its conversion to insurance.

Let those who apologize for American Medicine be the ones to advocate Socialistic schemes. We believe American Medicine to be the most efficient, scientific, progressive, and economical in the world. But even more important—it is private enterprise by free men and women. Let Alameda County retain and defend that of which we are justly proud—traditional, honorable, *private practice.*

Above statement was submitted on October 17, 1944, by Sidney Parkinson, M.D., on behalf of the 21 Alameda County physicians whose names appear below:

Harry Templeton
Forrest Kracaw
Douglas Dickson
Dorothy Allen
Murphy Reeves
Roy Nelson
Dexter Richards
George Reinle
James Harkness
Gertrude Moore
Sidney Parkinson
Theodore Weller
Abilio Reis
Philip Dick
Fletcher Taylor
Charles Hall
O. T. Leftwich
Winfred Hart
Douglas Ream
Norman Leet
William Donald

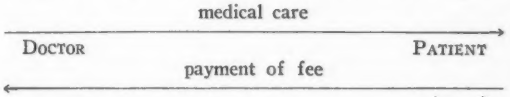
PRIVATE PRACTICE



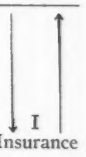
The natural patient-doctor relationship is reciprocal:

Medical care by the doctor—payment of fee by the patient.

PRIVATE PRACTICE PLUS INSURANCE



Insurance does not disturb the natural patient-doctor relationship.
Insurance benefits are paid to the patient.

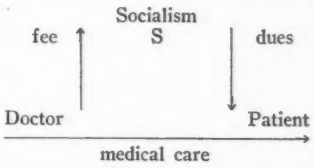


Insurance requires no special panel; it recognizes the entire licensed medical profession.

Insurance Plans Pay the Patient * * * * * * * * Socialistic Plans Pay the Doctor

Children's Bureau
Wagner Act
Calif. Phy's Service
Kaiser Health Plan

These plans have their one *essential* feature in common: complete control of cost to Patient and fee to Doctor. This feature is the *trademark* of *Socialism.* It distinguishes Socialism from Insurance.



Socialistic plans invariably and characteristically usurp the financial transaction. Such plans may differ in all other features, but they never fail to aspire to be Medicine's fiscal agent.

Socialism generously grants free-choice-of-doctor.

What it wants is control of the fee.

Control of the *fee* gives *control* of the *doctor* and of the practice of medicine.

Likewise, organizational control of the dues gives a measure of control over the patient.

Alameda County doctors reject C.P.S. until it is converted from *Socialism* to *Insurance* by the single step of paying the patient instead of the doctor.

II

Statement by 44 Alameda County Physicians

(Following statement was sent out by 44 Alameda County Physicians.)

* * *

Oakland, California, November 22, 1944

Dear Doctor:

Again the physicians of Alameda County are being asked to turn against California Physicians' Service. You have no doubt received a letter recently, bearing the names of twenty-one Alameda County physicians, urging that you send in your resignation as a professional member of C.P.S.

Some of us—and we have listed our names on this letter—have the feeling that a matter of this kind should properly come up through the regular channels of organized medicine. We have a County Medical Association, a State Medical Association and a Board of Administrative Members of C.P.S. We believe that these are organized for the purpose of providing checks and balances in the usual democratic manner and that no minority group of individual physicians should hold itself above these organized bodies in attempting to bring about changes in a going concern. As a matter of fact, the proposal now being made by this minority has twice been debated before the C.M.A. House of Delegates and defeated on both occasions.

At this time we do not wish to take issue with the statements made in that letter recently sent to you. Instead, it is our thought that the *method* of placing this matter before our members should be through regular channels, not in the form of a personal campaign. Then, if the will of the majority is made known, it is only fitting that all of us accept that verdict and guide our own actions accordingly.

We simply ask that you maintain your membership and keep an open mind on the subject of C.P.S. We suggest that defects in its present setup should be remedied in the democratic way and not through a revolution within our midst. The only effect of the revolutionary method is to create a vicious negative reaction on the part of the public, not only against the minority group fostering this attack but against the entire profession.

This letter is sent to you primarily in the hope of creating unity, not only within our county but within our State.

Fraternally yours,

C. L. Abbott	George Kleeman
H. C. Aitken	Harold W. Lambert
K. W. Benson	Elwood W. Lyman
Katherine Scott Bishop	Clifford W. Mack
Josephine Borson	H. Gordon MacLean
George F. Calvin	Oscar O. T. McAllister
Joseph D. Cieri	Robert J. Oakes
Leela S. Craig	Clarence W. Page
H. W. Crane	Ernest W. Page
Whitfield Crane	Jane T. Paxson
R. A. Crum	Robert Redfield
J. Lloyd Eaton	Miriam Rutherford
Grant Ellis	Henry A. Shefoff
Arthur Fleisher	Paul R. Shumaker
David Hadden	Robert A. Stewart
David Rodney Hadden	Harold G. Trimble
Dean E. Hart	Stanley R. Truman
E. Schulze Heald	R. G. Van Nuys
James Hilgeson	A. L. Velarde
T. Richard Hofman	Clyde T. Wetmore
S. A. Jelte	J. Dwight Wilson
Percy H. Jennings, Jr.	Lois S. Wilson

III

Council Chairman Gilman's Covering Letter to Statement by C.M.A. Executive Committee

This letter was sent to members of the Alameda County Medical Association, and to secretaries of component county medical societies.

* * *

Dear Doctor:

You were recently sent a letter by a group of physicians in Alameda County who expressed disapproval of the existing organization of California Physicians' Service and who asked that you express your opposition to C.P.S. by resigning your professional membership.

The views of this group of doctors are diametrically opposed by those of the California Medical Association, which has at all times been backing C.P.S. on the orders of its House of Delegates. The Council of the C.M.A. acts as the official body of the organization in between the meetings of the House of Delegates.

Enclosed you will find a statement prepared by the C.M.A. as an immediate reply to the statements made by the group of Alameda County doctors. A more complete reply will be published in the December issue of CALIFORNIA AND WESTERN MEDICINE, along with the original letter. Meanwhile, you may well find the enclosed remarks worthy of your consideration.

We ask that you maintain your membership in California Physicians' Service and continue to give it your full support. Such defects as exist in California Physicians' Servce can be remedied in an orderly fashion by action of the House of Delegates while sitting as Administrative Members. One of the reasons that the House of Delegates was made the Board of Administrative Members of California Physicians' Service was to permit free discussion and action to insure that California Physicians' Service conform to the desires of the profession. This is the democratic process.

Fraternally yours,

PHILIP K. GILMAN, M.D.,
Chairman of the Council.

* * *

IV

Reply Statement to Letter Signed by 21 Members of the Alameda County Medical Association

(Statement which follows is submitted by the Executive Committee of the California Medical Association.)

1. *Indemnity vs. Service.* The gist of the Alameda County complaint is that C.P.S. should be an indemnity insurance company engaged solely in reimbursing patients for all or part of the cost of professional services. As you know, C.P.S. was created by the C.M.A. as a medical *service* plan, and not as an insurance company. To set the record straight, the question of whether the medical profession's own plan should be an insurance company or a service organization has twice been voted down by the House of Delegates. At the special meeting in December, 1938, when it was voted to create C.P.S., the House almost unanimously rejected a proposal that C.P.S. be created as an insurance company. The idea of indemnification was unqualifiedly rejected for the reason, true then and still true, that the people want service, not a partial reimbursement of costs. Again in May, 1944, while the House of Delegates was in session in its capacity as administrative members of C.P.S., representatives from Alameda County introduced a resolution urging that C.P.S. be converted to an indemnity plan on

an insurance basis. This resolution was debated and rejected by the House.

2. *Public survey proves that cash indemnity doesn't satisfy public.* There was good reason for the rejection of a cash indemnity plan. This reason is a fundamental one. The people (and it is *they* who will untimately determine the future of the medical profession) do not feel that insurance cash reimbursement, leaving an exposure to additional bills, answers the problem of the cost of medical care. As stated by Dr. McCann, in describing the Massachusetts Medical Service, "Only a service contract for the entire family in the lower income brackets, under which no extra charge is made beyond the corporation allowance for the service, will give needed protection to this group." (A.M.A. Journal, Oct. 7, 1944, pp. 341-42). The public wants service without further exposure to burdensome expense, and one way or another it will get it.

3. *Service does meet demands of public.* To date, we know that a majority of the people are willing to vote against Government compulsion if they have available *service* from the medical profession on a reasonable prepayment basis. The independent and impartial survey made by Foote, Cone & Belding, with which you are familiar, definitely demonstrates that (1) a majority of the people in this state are not satisfied with private practice of medicine on a fee-for-service basis, (2) a majority of the people are, however, perfectly willing and desirous of having the medical profession do the job, if it does so on a service basis, (3) if the medical profession fails to do the real job, a majority of the people are perfectly willing to listen to politicians and vote for state medicine. It is our opinion that, in the light of the known views of the public, to convert C.P.S. to an ordinary insurance company would be a form of professional suicide.

4. *Instead of sabotage Alameda County doctors should again ask House of Delegates to decide.* If the group of physicians in Alameda County still disagrees with the reasoning of a majority of their fellow physicians, they should again seek debate in the House of Delegates, instead of sabotaging from the sidelines. The Association would welcome free and open debate on this subject once again in the House of Delegates, because it is confident that the course taken has been the only wise course, serving the best interests of the *profession and the public alike.*

5. *There is a difference between our plan (C.P.S.) and lay-controlled plans, public or private.* The physicians from Alameda County attempt to link California Physicians' Service with Government plans such as the Children's Bureau and the Wagner Act, and with lay-controlled private industry plans such as the Kaiser plan. One moment of reflection will demonstrate the fallacy in this approach.

What control does the medical profession have over the policies of the Kaiser plan? None, of course. What control would the medical profession have over Government medicine? None, of course. What control does the medical profession have over the policies of C.P.S.? The medical profession *owns* C.P.S. and is its sole control. The trustees of C.P.S. are elected by the administrative members. The administrative members are the delegates and alternates to the C.M.A. House of Delegates. Every member of the Association, through his delegates, is a part owner of C.P.S. The group in Alameda County has fallen into the error of considering C.P.S. *as somebody else's plan,* as some impersonal entity not connected with the doctors of California. Actually, and this is important, C.P.S. is not a third person or stranger or a company, it is you, it is *"our C.P.S.",* not *"that C.P.S."*

6. *C.P.S. has created an enormous good will towards California medicine.* Certain statements in the letter from Alameda County must not pass unchallenged. It is said: "Would C.P.S. prevent State Medicine? There is not the slightest evidence that appeasement schemes discourage Socializers." This is a non sequitur. It isn't socializers that C.P.S. is intended to impress or influence. It is the people of the State of California and of the Nation. C.P.S. has succeeded in influencing thought throughout the Nation far beyond what could reasonably be expected from its small size. It is favorably known in both Houses of Congress and is *not* attacked by any senator or representative, regardless of political party. C.P.S. is *not* an "appeasement scheme"; it is an effort to furnish real medical service on a prepayment basis and to do a complete job for the public. Cash indemnity, giving only partial relief from costs of medical care, is the *real* "appeasement scheme" and the public knows it.

7. *Blue Cross Plans are also service plans; they are not insurance.* In the letter from Alameda County it is stated: "Blue Cross and other hospitalization plans are true insurance. Hospital management insisted upon it." This is not a fact. Blue Cross plans are *not* insurance; they are service plans in which the hospitals underwrite hospital care in the same manner that professional members of C.P.S. underwrite professional services. There are today three Blue Cross plans operating in California. The extent to which these three plans actually call upon the hospitals to assume the ultimate financial responsibility under the service plan arrangement of the Blue Cross Commission of the American Hospital Association varies to some extent but the underlying principle of a *service organization,* not an insurance company, is inherent in the entire Blue Cross set-up. As a matter of cold fact, two of the three Blue Cross organizations in California today are engaged in litigation with the California State Board of Equalization, in suits which have as their purpose, among other things, to prove that these Blue Cross plans are engaged in a service business and not an insurance business. These suits in themselves are sufficient to refute the claim of the Alameda County physicians that "Blue Cross . . . is true insurance."

8. *Resistance to all change will kill, not preserve, private practice.* The letter states: "Let Alameda County retain and defend that of which we are justly proud—traditional, honorable PRIVATE PRACTICE." Needless to say, the California Medical Association has no objection to private practice, nor any desire to stifle it; but the Association begs to differ with those who think that by sabotaging C.P.S. private practice can be retained. They overlook the fact that the future of medicine is a matter in which the public as a whole will have something to say, and that the surest road to politically dominated medicine is to let the people feel that the medical profession with a head-in-sand attitude has only the desire to resist change and deny even the existence of an economic side to medical care. If we want to be engulfed and to lose *all private practice,* then by all means let us take the myopic view that all that we have to do is sit tight and defend "private practice."

9. *Service plans are not unique to California.* The letter from Alameda County states that California is almost alone in having a state medical association attempt to impose a prepayment service plan on its members. Granted that California was a pioneer in this field, it should be stated that Michigan followed California, that Massachusetts, New York, New Jersey, Colorado, and other state medical associations have now established pre-

payment service plans. In each state where thought has been given to the subject, the profession has chosen service rather than insurance.

In 1940 the Michigan Medical Association formed the Michigan Medical Service, which is comparable to C.P.S. Apparently whenever a majority of the physicians in a state undertakes a positive step in an effort to meet the problem of the costs of medical care, a minority within the profession, although out-voted, continues to attempt to defeat the will of the majority; for in Michigan, in spite of the success of the Michigan Medical Service, which now has over six hundred thousand members, one county has continually endeavored to kill the plan. In Michigan that county has not been successful.

10. *So-called trend towards conservatism.* The 21 doctors from Alameda County state: "The development of C.P.S. coincided with a surge of Leftism throughout California. With a trend toward Conservatism it is possible that pressure for such schemes may subside." It is aparent that the basic desire of the group from Alameda County is to stand pat and resist all change. It is also apparent that they think that the public trend is toward conservative resistance to change. To demonstrate that the group of doctors in Alameda County is engaging in wishful thinking, it is only necessary to refer to the national election held November 7th.

It doesn't take a great deal of perception to realize that the profession is not going to assist itself or the public welfare by timidly approaching the subject of costs of medical care, or by denying the existence of any need even to think about the subject.

(Signed) C. M. A. Executive Committee.

V

California Consults An Expert*

(Excerpts from an article in *Minnesota Medicine*)

Problems in distribution of medical services have been brought to a head in such states as California and Michigan as a direct result of the war.

Solutions which might have required many years of trial and error to evolve, have been forced into an advanced development, especially in California; and what has happened and is happening there may well be examined closely by doctors everywhere as a laboratory experiment in meeting issues which will eventually confront other states.

The California Physicians' Service, providing prepaid medical care to low-income families, had a slow and uncertain start some years before Pearl Harbor. The overnight growth of war industries, and the tremendous influx of workers occasioned by the war, presented problems in medical srevice which would not wait for solution. Leaders in organized medicine in the State made use of every available tool to keep from being overwhelmed. They expanded their California Physicians' Service, made unprecedented alliances with war plants, housing authorities and health officials in the hope that the delivery of medical services could be kept in the hands of private medicine and that government bureaus could be kept from stepping in and assuming the responsibility.

Profession Divided

In that respect, their efforts have so far been successful. But it is clear from published statements by officials of the California State Medical Association that the battle is not yet won in California, and that one of the hurdles has been the difficulty encountered in lining up the members, themselves, behind a united statewide plan of action.

The same difficulty has been encountered in many other states where initial experiments are now going on in the provision of prepaid medical service under medical association sponsorship. Misunderstanding, indifference and actual hostility on the part of individual physicians or component societies have threatened many another plan which had the wholehearted support of administrative bodies and association houses of delegates.

It is entirely in line with the pioneering spirit of the California organization that an interesting new step in solution of its difficulties has recently been taken in California. A capable and experienced public relations firm was asked to make a survey of the whole problem. The report of a representative of this firm, Mr. John R. Little, of Los Angeles, was presented recently to the California House of Delegates and is reprinted, here, in condensed form, from the July issue of CALIFORNIA AND WESTERN MEDICINE for two reasons. The first is that it provides an unique estimate by a qualified outsider on the social problem that confronts all medical organizations in these times. The second is that medicine's job today does not differ greatly in its public relations aspect from the job that has confronted many other groups in meeting the changing conditions of American life. It seems clear, therefore, that medicine will need the aid of such experts as Mr. Little, if it is to remain in control of its own house and avoid encroachment of government in the control of its essential functions. Minnesota has largely been spared the difficulties which are so acute in the delivery of medical service in California; but Minnesota doctors, also, should pay careful heed to the observations and advice given to their California colleagues in this report. The time is coming when they, too, may need such guidance. . . .

The highlights of Mr. Little's report follow. . . .

Plain Talks on Medical Care Insurance

(Reprinted from *New York State Journal of Medicine*)

PLAIN TALK, I

The medical profession of the nation is faced with a problem of great magnitude and importance. It must *sell* voluntary medical care insurance.

The House of Delegates of the Medical Society of the State of New York has provided for the establishment of a Bureau of Medical Care Insurance with a full-time director and staff to undertake this job for this State. That is all to the good.

Fortunately, this Society is already possessed of a Public Relations Bureau with experience and competence in presenting the views of medicine to physicians and the public alike. It must be used to capacity.

Also this Society has a JOURNAL. Its pages can tell a story. Those pages can tell the story of voluntary medical care insurance. They can tell that story to physicians who need to hear it. They can repeat that story in new words. Over and over. If they are used.

The Society is well equipped with tools for the job. Does it know how to use them? Time will tell. The Federal government knows how to use them. To sell what we consider an inferior product. Government-controlled medicine.

Many people sincerely believe that government medicine is good. We believe that voluntary medical care insurance is better. Our problem is simple. We must make more people believe that voluntary medical care insurance is better.

But first we must believe that ourselves. Enthusiastically and unanimously. You can't sell what you do not

* From the Department of Medical Economics. Edited by the Committee on Medical Economics of the Minnesota State Medical Association.
Excerpt is from "Minnesota Medicine," October, 1944, page 833.

believe in; you can't expect the new Bureau of Medical Care Insurance to sell your insurance to people if you yourself do not believe in it. Certainly, it's your plan. Of course you know that it is medicine's answer to compulsory Federal insurance. You have read that time and again. You have heard it mentioned in your county society meetings—if you were there. You realized, naturally, that your various county and state societies' medical economics committees were "doing something about it." But what have you yourself done about it? Some things you can hire done. Others you must do yourself.

If this JOURNAL is to serve you, and the common cause of medicine and the public interest, it must speak the truth. That is essential to good public relations.

Let's go! Not all of us believe enthusiastically in what we have to sell to the public. Some of us are hazy as to what it is all about. Therefore many of us can't talk to our patients or to the public persuasively and convincingly. So we say: get some one to sell the idea for us. That's a step in the right direction, but it is only a step. *Your* services are involved; *you* have to make any voluntary plan work; not only do you have to render the purely medical service to the subscribers, but you also have to do it enthusiastically. Otherwise you are asking your Bureau of Medical Care Insurance, your Public Relations Bureau, and this JOURNAL to help sell a gold brick, not only to the public but to other physicians.

This is plain talk. But we are committed to a voluntary insurance plan and it must work by virtue of the wholehearted participation of all of us in it.

"The people do not want Federal medicine," says Mr. John R. Little.[1] "They only want what they have been told *will result from Federal medicine*. The pressure groups and the politicians cannot enact Federal medicine without the clear will of the people . . . I suggest . . . you think only of what instrumentality you can supply which will satisfy the people's wants—an instrumentality which will be superior to anything politicians can offer. . ."

It will be, but only if physicians make it so. This does not mean *some* of the physicians of the State; it means *all* the physicians, and the proper use of *all* public relations media we possess.

* * *

PLAIN TALK, II

Many of us physicians are too preoccupied with the little trees of medicine to perceive the forest. We argue about details, procedure, and the like, endlessly, with each other. Thus we are prone to stress the differences of opinion which undoubtedly exist on many matters, while forgetting that we, the physicians, representing medicine, the public as the consumer, and government, the political agent of the people, are all in agreement as to the ultimate objective—better medical care for everybody. The people are interested in that.

We all want it. We all want it as soon as possible. The profession of medicine exists for no other reason than to provide it. The public rightly expects it from the medical profession—and gets it, by and large. Government can't do without it if it is to fulfill its constitutional pledge to promote the general welfare, of which the public health is a vital part.

The public knows something about insurance. It has bought billions of dollars worth of it, life, fire, accident, and the like, to its benefit.

Government knows about insurance, too. Because government is, after all, only the people when it does not forget and become biggity.

And the doctors, who are just people also, in spite of the language they use at times, are insurance-minded—couldn't carry on without it, in fact; life, fire, automobile, war-risk, accident, and all that.

So everybody is insurance-minded. And what is there to argue about? Spreading the cost? No; everybody agrees on that point. No argument. Ah! What are we proposing to insure against? The *costs* of *illness*. Sounds simple. Until you try it.

You can *assure* health only to a limited extent. That's preventive medicine and eugenics.

You can also *insure against* sickness. You can *insure against* the *costs* of being sick. If you know *how*, and *how much* the cost are and *how many* are going to be sick, and for *how long*. Plenty of room here for argument. Because you *have* to be right. You can't sell the insured people a gold brick. At least, not in this State. The law says so. If you promise something to people for fulfillment in the future, and people pay you in advance for delivery, you have to deliver just what you promised them you would. And, furthermore, people must be satisfied with what they get as a result of that promise which you made to them and for the fulfillment of which *they paid in advance*, often far in advance.

Now, you can pay off your insurance obligation either in services or in money. Some think one way is better, some think the other preferable. But in any event, you propose to meet *costs* of illness, and most plain people think of meeting *costs* with *dollars*. They understand that. Years of experience with life and fire insurance have taught them. Thanks to the businessmen, who have made this plain, reasonably simple, and prompt.

And so medical care insurance to meet the *costs* of unexpected illness must be financially sound, must pay where needed with as little red tape as possible, and must satisfy a need of the consumer, at a *price* he can afford.

The medical profession thinks it has had sufficient experience with the plans which have been in experimental operation in this State for many years now, to be able to say that such voluntary insurance can be provided for the public.

Eventually, government will assist in the operation and furthering of such plans, in our opinion, rather than to operate its own scheme of compulsory "health" insurance disguised as social security or whatever seems at the moment to be politically expedient because, after all, government is only the people and the people get what they want in this country.

Eventually the people will want the kind of medical care insurance of which the doctors approve, if the doctors will advise the people about it, because the doctors have always dealt honestly with the people and the people respect that way of doing things. But the doctors will have to inform the people by every means at their disposal of the advantages of voluntary prepaid medical care.

* * *

PLAIN TALK, III

There is one good point about being in agreement about something—you can go about your business expeditiously without wasting a lot of time squabbling.

Take voluntary prepaid medical care, for instance. There used to be some doubt and uncertainty about it; would it work? Did the doctors think it a good thing? How did the people feel about it? Would the medical profession support it? That was long ago.

Now the medical profession is squarely behind it, the public wants it, nobody opposes it who is sufficiently informed on the subject to know what it is all about. Take one aspect of it, for example. How can any plan to insure people against illness work unless the doctors are behind it? The whole principle of insurance depends upon *enough* lives, or houses, or automobiles of just plain people who pay premiums to meet the *cost* of the thing they *insure against;* in this case, *illness*. Next there must

1 California and Western Medicine, Vol. 61, No. 1, July, 1944, p. 12

be enough doctors to treat the people, good doctors, too, or the people won't buy the insurance. Why should they put up with other than the *best* medical care? When they buy something they want the best that can be had. That is why the doctors themselves, through their Medical Society of the State of New York, are sponsoring voluntary prepaid medical expense indemnity insurance. That is why the Medical Society is setting up, right now, a Bureau of Medical Care Insurance with a full-time director so that the people can have the kind of insurance they want, backed by the doctors themselves. Such insurance is *safe* insurance.

Many of you remember the watch that made the dollar famous. It was good because it had responsible people and good workmanship and materials in it. Voluntary medical care insurance backed by responsible doctors is good for the same reason. Such insurance provides medical care of a quality that the doctors, through their State Medical Society, propose to furnish to those who want to buy insurance against illness.

It is not to be anticipated that you can start with a perfected plan. You can start with an actuarially *sound* plan, and you can set your upper limits of acceptance in a manner or at a level to include 94 per cent or thereabouts of all the people in the country. Then, after you have enough subscribers to your plan you can modify the details as may be necessary, and as accumulating *experience* seems to direct. But you certainly cannot go until you start.

Even though the people want prepaid medical care insurance it will take some time to cover 94 per cent, say, of the people of the country, or even of this State. Policies have to be written and marketed. So it's up to us to take the driver's seat and deliver the goods, isn't it? What is to stop us? Nothing that we can think of at the moment. Doctors have never yet been stopped from doing anything which they thought was for the public interest, and for the betterment of the public health, come hell or high water.

* * *

Plain Talk, IV

Speaking before the Fifth District Branch Meeting of the Medical Society of the State of New York, at Utica, September 19, 1944, President Herbert H. Bauckus said, in part, "Man in his better moments has sympathized most hopefully with the proposition that all men are created free and equal. In the practical application of this thought is found again and again the strength and the faith that has nurtured our liberty—that has made America great. So, too, do we of the profession of medicine adhere steadfastly to the belief that all who live shall benefit alike according to the skill, ability, and resource of the highest developments in medical science available today. . . ."

President Bauckus called upon the responsible agencies of government charged with the responsibility of providing for the needs of the economically unfortunate to secure for these the same quality of medical care available to others.

"That this group, doubly unfortunate when ill, do not secure it, is not our fault—rather it is the result of the effort of the Boards of Social Welfare to buy cheap medical care. We do not want the product adulterated, no matter who pays for it. Political welfare medicine, cheap and hastily conducted school examinations, crowded and undersupplied clinics—we do not want them. Why do those outside of the medical profession insist that we shall have any such impersonal and poor medical care in this richly endowed America of ours? . . ."

Why, indeed? Because public business is that way in the nature of things; public officials, hard-working, ill-paid for the most part, some appointed for political reasons rather than for their knowledge, always under critical fire for their expenditures of public monies, are not in a position to do as they please. Restrictions laid down by higher authority govern, often under penalty for noncompliance of loss to the communities or districts or states of monetary grants-in-aid or rebates of tax monies. This is the curse of subsidy. This is the compelling reason why physicians look with disfavor upon the tendency to expand schemes for government or government-controlled practice of medicine.

"Our interest in preventive medicine likewise calls for the highest standards. We educate against epidemic disease, careless living, dangerous working—we warn against gambling with health and disease.

"Why do we need to have so many organizations to cope these many weary years with the problems of insanitation and preventable disease? I think a study of this question will reveal three main causes: (1) lack of leadership in the profession of medicine in public health procedures and their successful application to a properly informed people; (2) inertia and lack of carry-through to the use of our best medical knowledge on the part of officials of government—executive, law-making, finance, judicial; (3) health departments and boards of social welfare hampered by undermanned personnel, lack of funds, and political considerations.

"Our part, then, is to assume to the full our rightful leadership in the entire fields of the medical arts and sciences. No others are trained to understand or do as well. We ourselves do better. What does it profit anyone to keep with us this great preventable scourge, tuberculosis?

"I have no patience with those who quote statistics of 100 deaths being relatively unimportant when compared to 1,000 deaths. There is no place for coldness, and every place for warmth and mercy, in modern medicine."

Warmth and mercy, compassion, tenderness, the human relationship of one individual to another, the practice of medicine, or nursing? Can anybody visualize a Federal Warmth and Mercy Administration? A State Department of Compassion and Tenderness? The strength of government should lie in its impersonality, in even-handed administration of justice under the law, in the honesty and impartiality of its executives, in the incorruptibility of judges, in the accessibility of the courts of law to all.

Because there is this difference in the very nature of constitutional government and the practice of medicine, the government has no place, and, if constitutional, a government of laws, no sympathy, by definition, with the practice of medicine. It should have, quite properly, regulatory powers over the practice of medicine, provided these powers are wisely exercised under statutes which recognize the freedom necessary to the proper exercise and development of that which is partly a science and partly an art. But, as Dr. Bauckus says, leadership must come from within the informed profession. With assistance, not meddling, with lawful regulation, not control, by government. Failure by government to recognize these limitations, failure to exercise them, is to debase a profession, to demean government, and to substitute coldness for warmth, impersonality for a necessary humanism quite proper in the practice of medicine.

"To provide for the cost of medical care is a problem we have earnestly and considerately discussed with society in general and the individual patient in particular. We believe that our efforts to found voluntary prepayment medical care insurance plans in New York State are gradually bearing fruit. The establishment of a medical care insurance bureau with adequate personnel

under the aegis of the Medical Society of the State of New York is a decided forward step, and evidence of our faith in the public appreciation of independent medicine.

"Any sane consideration of the cost must put hospital and medical care among the foremost needs. Food, clothing, shelter, medical care—they are essentials and not to be entrusted to the vagaries of chance. Our leadership must be constructive in the emphasis upon liberal public education in preventive medicine and the care of the mind and body in health and in disease. We cannot delegate our responsibility in this regard. . . ."

We have, however, much to learn. If we cannot delegate our responsibility, we must exert our authority within the profession to enlarge our plans for voluntary prepayment medical care insurance. Our own profession must be educated, and quickly, to acceptance of this responsibility and to the necessity for the widest possible coverage of the population. It is hardly practicable, even if it were desirable, to insure one-half the employees in an industrial plant. Which of us would insure one-third of his automobile or one-sixth of his house?

Public appreciation of independent medicine seems to be evidenced by its support of the practitioners and the institutions of that kind of medicine. But there is much danger of alienating public support and confidence by too great independence. There is a happy medium and we would do well to take public need as a criterion and proceed accordingly.

* Public Relations Bureau of the Medical Society, State of New York, 292 Madison Avenue, New York 17, N. Y.

On Impending Federal Legislation—Wagner-Murray-Dingell Bill

*A Letter from Lowell S. Goin, President of the American College of Radiology to its Members.**

(COPY)

THE AMERICAN COLLEGE OF RADIOLOGY

540 North Michigan Avenue, Chicago 11

November, 1944.

Monthly News Letter, Number Thirteen

Dear Doctor:

. . . The normal functions of the College are now being resumed, and the officers have plans that will increase the scope of its activities and make its program of even greater value to the specialty of radiology and its practitioners in the years to come. The coöperation of the entire membership is needed for the immense job ahead of us.

We are living in a period of great social and economic change, in times which, even though trying, are of tremendous interest. Greatly affected by these changes, and struggling to adapt itself to them is our own profession of medicine. The problem is complicated by the natural resistance offered to change by all living things, and by the far reaching implications of the changes proposed.

What is about to happen to our socio-economic world? What may be done about it? Can these changes be stopped? Should they be stopped, or only guided? These are questions which are presently occupying the minds of a very large number of thinking people, and the answers are not readily given.

Many of us think that we are in the grip of great social forces whose power and strength have been gathering for years, perhaps for centuries. Progress consists essentially of changes, and our chief error lies in assuming that change is necessarily bad, on the one hand, or on the other that all changes represent progress. Truth lies between these two views. Changes are occurring, and are going to occur, in many aspects of life, but that change which most concerns and interests us is in the methods of the distribution of medical care.

No thoughtful person can deny that there are grave faults in the system by which medical care is now distributed. No thoughtful person can agree that an ideal method has yet been devised. Agreement is nearly unanimous, however, that the solution does not lie in socialized or Federal medicine. Those who do so believe are simply refusing to look at the facts accumulated by the European experience with medical care thus administered.

In spite of these considerations, it is by no means impossible that socialized medicine will come upon us, if not as proposed in the Murray-Wagner-Dingell Bill, than in some other fashion. If this be the case, it behooves us to consider what the position of radiology may be when our social planners have brushed the star-dust from their eyes and have settled down to the solid and practical matters of votes, patronage, and dollars to be gleaned from their welldoing.

The pending legislation is by no means dead, or even dormant. Hearings were held last month at which several of our leaders testified. Dr. Roger Lee of Boston, President-Elect of the American Medical Association appeared, and made a most favorable impression on the Senate Committee. and for this we should all be grateful.

The language of this proposed law has a certain vague grandeur coupled with a murky character which makes it nearly impossible to be sure just what the authors intend, but centers with diagnostic facilities are mentioned fondly. Since it seems unlikely that it is intended to erect centers to house a doctor with a stethoscope, one might assume that the diagnostic facilities referred to will be radiological and clinico-pathological. This, of course, would very neatly dispose of the private radiologist. Although the disappearance of the private radiologist is a small matter in comparison with the catastrophic effect of such legislation upon the public health, it nevertheless has some interest for us. We have, then, a triple duty: first, (and smallest) the guarding of our own specialty and the prevention of the loss of its benefits to mankind. Second, to assist in the defense of the medical profession (our medical profession) against its own destruction. Third, (and most important) to prevent the lowering of health standards and the increased death rate which will inevitably follow the enactment of such legislation.

Toward that end we have but one course now apparent, and that is the encouragement and support of voluntary medical care plans. I have already referred to the natural tendency to resist change, and I must now remind you that it may be stated as an axiom that whenever the people find beyond their reach something that they think should be available, the people will always make that thing available. Voluntary, physician organized and operated, medical care plans can solve the problem. Such plans *are* beginning to solve it, and the purpose of this message is to urge the radiologists of America to encourage and actively support these plans.

Sincerely yours,

(Signed) LOWELL S. GOIN, M.D., F.A.C.R.,
President.

* Dr. Lowell S. Goin is president of the California Medical Association. His letter to fellow-radiologists should be of equal interest to members of the California Medical Association.

In the "Paradise of Wisdom" by Ali Ibn Rabban, a work dealing with medicine, philosophy, embryology, psychology and astronomy, mention is made of elephantiasis, lupus and cancer.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Dec. 19, 1944.

IMPORTANT NOTICE

U. S. NAVY WANTS YOUR HELP

Medical Department of the United States Navy has urgent need of 3,000 additional surgeons.

Our Navy is understaffed by about 7,000 physicians.

Coöperation of every California physician is urgently requested.

From "Men at Worst" to "Men at Best"

California Surgeon Meets Amazing Heroism

From the confines of San Quentin's high walled prison for 28 years, Dr. Leo. L. Stanley, chief surgeon and at times acting warden, saw "Men at Their Worst." His popular book a few years ago carried that title.

Dr. Stanley, now a commander in the Navy and just returned from three years of sea duty—much of it aboard a hospital ship in the fighting areas—knows what title would be appropriate for another book, should he decide to write one. It is: "Men at Their Best—the Story of Bluejackets and Marines at War."

For more than a score of years, Dr. Stanley witnessed men at their worst in an institution provided by society for those who broke the rules of the game. Some of them despaired, some lost hope. Sometimes on the operating table a man openly wished to die; sometimes life in San Quentin Prison wasn't worth fighting for.

Now, 32 months after the Pearl Harbor attack, when Dr. Stanley was called to active duty, the former San Quentin surgeon has seen men fighting for their lives on the operating table when the odds were stacked against them. . . .

His ship was in the Kwajaleins during the battles for Roi and Namur; it was at Enjwetok, Saipan and Guam.

It arrived at Saipan on D-Day plus two. . . .

Dr. Stanley recalls a time in the Saipan invasion:

"We had come down from Saipan with hundreds of patients, many of them seriously wounded. It took us a week to make the trip and all of us had been tense during the four days we had stood by to receive these patients with the battle going on before our eyes.

"For some there was little sleep. Surgeons were busy day and night."

Many surgeons, he said, handled more than 30 operations in a day.

"Speed and prompt surgery," Dr. Stanley says are the key to medical action. Sometimes it required more than medical science and prompt surgery to save a man's life; it required the patient's own tenacity and nerve, a willingness to stick it out and see it through. Once in a while a man's arm or leg had to be amputated and a man had to be of iron to watch it. These Army, Navy and Marine Corps men, Dr. Stanley says, were "Men at their best."

Life aboard a hospital ship, while interesting, wasn't always easy. When the seas were high and the ship tossed, a surgeon would wrap a leg around the operating table for support. And yet nothing deterred from prompt ministering of men.

The ex-San Quentin surgeon had words of high praise for Navy nurses, who, he said, for the most part are capable and efficient, and add a lot to the morale of the patients on board.

"Nurses are in great demand," he said.

And he was emphatic in pointing out the importance and necessity of blood plasma which oftentimes saves wounded men's lives even before they are transferred to a hospital ship or to a hospital base.

The Services Need More Nurses

Although more than 35,000 nurses are now serving with the Army or Navy, the need is by no means satisfied. During the next year it is estimated that something like 30 000 additional nurses will be required. Including 35,000 students now in training, the number of nurses available for service with the Army or Navy is estimated at about 195 000. In recent months the rate of enlistments has fallen off, and the Army and Navy Nurse Corps is making an effort to convince more nurses that their first duty in this emergency is to serve the sick and wounded among our fighting men.

Of course, this need puts a new strain upon civilian hospital staffs, already on desperately short rations, and the call for girls to study nursing and for women to take Red Cross courses in home nursing or to qualify as nurses' aides is increasingly urgent. The *Post* is glad to add its endorsement to the appeal of the services and the Red Cross for an increasingly large number of women with the necessary age and educational qualifications to contribute their skill and patriotic endeavor to meet the crisis in the care of sick soldiers and sailors and of the civilians who are left behind.

Draft Statistics on Physical Defectives

"Facts uncovered by the war concerning the physical unfitness of the men of this country are beginning to have their first repercussions. A Congress committee is exploring the situation revealed by physical examinations for the draft. Out of that exploration very probably is to come a renewed demand for broader Social Security—disability insurance, hospitalization, maybe a start toward state medicine for persons other than war veterans."

This paragraph, from the *United States News* of July 21, expresses the theme of several national magazines in recent weeks. The attitude is that because draft rejections have been high, state medicine is the only solution. Continuing, the *News* points out that at least 15 to 20 per cent of the ailments for which men have been rejected could have been corrected. It is conceded, however, that malnutrition may have been a major cause of bad teeth and tuberculosis. Mental disorders are so widespread, it is stated, that more than 30 per cent of the men rejected have mental diseases or mental deficiencies including illiteracy. Ten per cent have been rejected because of such manifest defects as missing arms or legs, blindness, and deafness. Syphilis and other venereal diseases have caused the rejection of 7.1 per cent. Heart ailments, tuberculosis, visual disturbances, and bad teeth are among the other leading causes for rejection.

Admittedly then, 80 to 85 per cent of the defects which have caused rejection by the military were not

amenable to medical or surgical treatment. They were caused in large part by poor heredity, malnutrition and bad environment, neglect of teeth, fractures, deformities, and many other conditions which might have been corrected early in life. The constantly repeated assertion that clinics operated by the government would have prevented such widespread physical disability has small basis in fact. The poorer districts of all important cities have long had large charitable clinics where the finest of medical and surgical care was available to that part of the population who were unable to obtain it privately. No amount of medical care can overcome the effects of ignorance, indifference, poor nutrition and bad housing...

If our government is sincerely desirous of improving the health of the nation, it will adopt a policy of universal slum clearance, and will provide proper recreation and playgrounds for city children. Instead of destroying food surpluses it will see that every child is properly fed. Every youth will be instructed as to the dangers of venereal disease and as to proper methods of treatment thereof. It will provide care for persons afflicted with tuberculosis and other prolonged and catastrophic illness. It will build fine municipal gymnasiums, swimming pools, and athletic fields in every community, and will encourage all children and young people to participate in athletic programs, rather than reserving participation for a small percentage of super athletes who do not need such training. Through a system of loans and subsidies it will be made possible for people of small means to obtain medical and dental care from private sources in a self-respecting and American manner.

These, and related measures, within one generation, would correct most of the defects which have caused such a high rate of rejection by the armed forces. The cost will be great, for it is expensive to eliminate slums, eradicate malaria, and carry on great mass educational programs. It is far easier, and more in line with standard political thinking, to establish some clinics, put more doctors on the government pay roll, and ignore the great basic evils which have been so startlingly revealed by the draft.—E. T. Remmen, Secretary, in *Bulletin* of Los Angeles County Medical Association.

General Kirk Addresses Military Surgeons

Major General Norman T. Kirk, the Surgeon General, made the opening address at the 52nd Annual Meeting of the Association of Military Surgeons in New York City this month. He outlined briefly the progress made by the medical profession in this war, which, he stated, had advanced medicine fifteen years. He then went on to say that the responsibility of the Army Medical Department did not end with getting soldiers well quickly and soundly but extended to giving those returning to civilian life "every possible aid to get them back on their feet." This, he explained, meant preparing them to return home and resume their normal way of life. General Kirk then called on the military surgeons to help educate the public on how to receive these men, the majority of whom, he said, want to be considered as self-reliant human beings and want a job—not a lot of sob-sister sympathy.

Critical Need for Army Nurses Continues

Out of 27,000 recruiting letters sent by the Army Nurse Corps to nurses classified as 1-A for military service by the War Manpower Commission, only 710 replies have been received, and less than a third of these are from nurses qualified for commissions.

While the drive to recruit Army nurses lags, the number of patients being evacuated from overseas to the United States has been increased almost 300 per cent. In addition, the overseas requirements for nurses continues to grow, with the quota for the month of December alone set at approximately 1,000 nurses.

Social Security Tax: Freeze Continues

One Per Cent Levy to Continue; President Roosevelt to Submit a New Plan

Washington, Dec. 16.—(AP.)—President Roosevelt's "reluctant" signature on legislation freezing Social Security taxes started a general congressional exodus from Washington today. Except for some State Department nominations under fire in the Senate, the social security legislation—blocking a scheduled increase from 1 to 2 per cent in pay roll and pay check taxes on January 1—was the last major hurdle between the 78th Congress and its final adjournment.

Announcement of the President's action drew a burst of applause when Speaker Rayburn made it in the House, where members generally had expected a veto.

There were less than 100 representatives on the floor at the time and many of them scooted away promptly to take up train and plane reservations for home.

Roosevelt's Statement

With only a few noncontroversial odds and ends in addition to the Senate nominations to be acted on, leaders set their sight for final adjournment not later than Wednesday.

Rayburn's announcement of the President's action was followed by White House release of a formal statement declaring it would be incumbent upon the next Congress to review thoroughly the methods of financing social security benefits.

The President said he still felt that the tax should have been allowed to rise on account of "Long run requirements of the Social Security System." He asserted the measure "Merely defers until next year" the necessary fiscal receipts. He added that it did not seem "Wholly sound to enact a tax law and then defer the taxes year after year."

"At an early date," the President said in the statement, "I plan to submit to the Congress a comprehensive plan for broadening and improving the Social Security system." . . .—San Francisco *Chronicle*, December 17.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Calls Bill Dangerous

Says Passage of Wagner Bill Would Foist Collective Medicine Upon America

"Political medicine as proposed in the Wagner-Murray-Dingell bill is too dangerous a trial balloon to launch upon the American people," Dr. H. Clifford Loos, head of the Ross-Loos Medical Group, told a representative of the Underwriters' Report in an interview on the prospects of socialized medicine and of alternative plans now being advanced from within the medical field.

"When the American farmer is desirous of going into collective farming, and when American business men desire to go into collective business ventures, and when America decides that the free enterprise and competitive system upon which this country was founded is no longer desirable, then will be the time for the collective practice of medicine operated by the government," he declared.

"We haven't reached that state yet, and if I know America we will never reach such a social status. Collectivism is not American, and it would be unfair to saddle collectivism on one segment of our population,

namely the doctors, and not include all of our citizenry in it. The doctors who are having to render the medical service should have something to say about how it is to be done, and we do not want political medicine.

"We in our profession are not as unprogressive as the reformers would picture us. We sense the need for doing something, and we are doing something. If the Government will leave us alone we will solve the problems. There is evidence all around us that the solution is near at hand. Who is better able to work out this puzzle than the doctors themselves? The passage of such a bill as is now before Congress would be such a hopeless thing for the medical man. The doctor does not want to be on a fixed income with no reward for merit, and because he would so unwillingly go into such a system of practice, the type of medicine practiced would be bound to deteriorate, and those who would be bound to suffer in the long run would be the patients of such a revolutionary scheme.

"When we talk of a better spread of medical care for the American people, what people are we speaking of? More and more, Government in this country has usurped the old private practice field. Already we have the industrially injured and sick treated by mandatory coverage. So this group has been taken away from private practice. All veterans of the wars receive medical care at the hands of the Government. Government has taken care of the insane and the tuberculous. Communicable diseases if institutionalized are cared for at public expense, and venereal diseases can be treated through public health agencies. Indigents, of course, are provided care. We are talking about medical care for those left out of these special categories.

"Of course many of our people who are eligible for medical care at public expense do not accept it. Most of the veterans of the last war choose to seek medical care through other channels than governmental agencies, and the fact that private tuberculosis sanitariums still thrive shows that government does not handle all tuberculosis cases. There will always be many of those eligible for governmental care who will not choose to accept it, and whose choice will be of their own selection."

Dr. Loos came to San Francisco to address the Commonwealth Club at a meeting on September 15.—San Francisco *Underwriters' Report.*

Social Security

House Committee Favors Tax Freeze

A poll of the House Ways and Means Committee indicated on November 29 it will vote, 15 to 8, tomorrow to "freeze" the Social Security tax, scheduled to double automatically on January 1.

Republican Leader Martin of Massachusetts said that all who expressed themselves at a meeting of the party steering committee late today also were in favor of the freeze, forecasting a heavy G.O.P. vote to that end.

However, some leading proponents of the "freeze" conceded the Presdient will promptly veto the measure if Congress passes it. They added that there are not enough votes to override a veto.

In that event the tax will be boosted a month hence from 1 to 2 per cent—meaning that the wage and salary man will pay the security fund $2 for each $100 he earns (up to $3000) and the employer will pay $2 on each $100 of his payroll.

A check of Ways and Means members indicated that six Democrats are inclined to vote with nine Republicans, to brush aside Administration recommendations and put thruogh the "freeze" bill. Eight Democrats probably will vote the other way.

There still is a possibility of overnight changes.

Congress was told today that leaders of organized labor want the security tax to double, as provided in the basic Social Security Act.

Martin H. Miller, legislative representative of the Brotherhood of Railway Trainmen, testified before the committee that his organization vigorously opposed the "freeze," and that he is advised that CIO and AFL leaders have the same view.

He said the increase "is absolutely necessary for a sound Social Security system. Otherwise, Congress later must subsidize the security fund with direct appropriations from the general revenues."

A representative of numerous industrial groups has pleaded for the "freeze," contending that the size of the security reserve fund is ample.

* * *

Wider Social Security to be Proposed

The Administration disclosed on November 27, it will present to the new Congress a proposal for vastly expanded social security coverage.

The disclosure was made even as the Administration encountered a burst of opposition in formally asking Congress to let the social security tax double on January 1, as provided by law.

A. J. Altmeyer, security board chairman, took the Administration's views before the House Ways and Means Committee.

Committeemen submitted him to vigorous questioning, indicating opposition to the tax increase, and causing speculation that Congress might vote to "freeze" the tax at 1 per cent.

Altmeyer said the increase to 2 per cent (against the pay of employee and also against the payroll of employer) is necessary for a sound social security program. He declared "the issue is whether Congress is going to make promises (of security) and not provide money to make good on these promises." If taxes are not increased, he warned, it may be necessary later to subsidize the program through direct appropriations.

Obligations are being created faster than reserves, he continued, although the obligations in large part will not fall due for 20 years.

Expansion Plans

The security board chairman then told the committee he would be back early next year with proposals for vast expansions.

He later gave a reporter a brief outline as follows:

1. Social insurance—A comprehensive system of compensation for part of the involuntary loss of earnings suffered by workers due to sickness and disability.

2. Old age and survivors' insurance—Coverage to be extended to agricultural workers, domestic workers in private homes, employees of nonprofit organizations and self-employed persons.

3. Administration of unemployment insurance, now in State hands, should be made a Federal responsibility.

4. *A Federal system of medical and hospitalization benefits.*

Altmeyer indorsed the Wagner-Murray-Dingell social security bill "in principle, but not in all detail." Dingell (D., Mich.) said the medical program in his bill "is not socialized medicine."

The plea that the social security tax be allowed to rise met with a cool reception by some committeemen. Representative Knutson (R., Minn.), committee Republican leader, said it seemed to him Altmeyer was "pleading for the increase so the Government will have more money to spend."

Chairman Doughton (D., N. C.) asked Altmeyer why "you missed the mark so far previously" in estimating the yield of the social security tax. The witness blamed the war and revisions in the act.

R. T. Compton of the National Industrial Council

asked the committee to "freeze" the tax at 1 per cent, saying employers and employees could "save" $9,000,000,000.

Representative Gearhart (D.-R., Calif.), committee member, said: "I believe it is revenue the Government is after, not money for old age pensions."

How Attempt to Regiment Holland Physicians Failed*

Translation of a letter addressed by the Netherlands physicians (and surgeons) to the "Rijkscommissaris voor het bezttze Nederl. Gebied" (Dr. Seys Inquart)

(COPY)

"It is with the greatest astonishment and indignation that we, Netherlands physicians (and surgeons) have taken notice of your latest instructions regarding the exercise of our profession. These instructions state among other things that doctors are no longer at liberty to lay down their profession, or to resign and give up the titles denoting their qualifications. This involves that you are again trying to force them to become members of the 'Artsenkamer' (a branch of the *Nat. Soc.* Medical Society). Those who should act contrary to your instruction are threatened with severe punishment.

"For generations we, Netherland physicians (and surgeons), have worked for the well-being of our patients and of this people. A high standard of medicine and hygiene has always existed in the Netherlands thanks to our practical and scientific labour.

"Our organization 'De Nederl. Maatschappij tot Bevordering der Geneeskunst' (the Netherlands Medical Society) was a 'trade-union' of the highest order. It worked according to the Netherlands standards and traditions, and its membership extended to practically the whole of the Netherlands medical profession. Of our own free will we have all resigned from our excellent 'trade-union' in order to prevent it being used as an instrument for terrorizing the Netherland medical profession.

"You then founded the 'Artsenkamer' which was to force upon the doctors the Nat. Soc. principles that are so absolutely and entirely alien to them.

"Mr. Rijkscommissaris, you should be well aware of the antagonism of the medical profession against this imported institution which is being imposed upon them. During the time of its existence the 'Artsenkamer' has time over and again come into conflict with the medical profession as a whole, and none of its aims have been attained so far, owing to spontaneous resistance. The organization has been and is greatly mistrusted by all Netherland doctors. You will remember having received in December, 1941, a letter, signed by 4,500 doctors, with the request to abolish the idea of founding an 'Artsenkamer' with the object of imposing Nat. Soc. principles in the region of medicine. The following out of the principles of racial prejudice, with its consequences of the elimination of lunatics and invalids and the sterilization of healthy people, shows in how far our solicitude was justified. Evidence of how the 'Artsenkamer' is opposed to the spirit and the feelings of the Netherland doctors was recently produced by the resignation of 6,200 doctors who decided rather to give up their profession than to join the 'Artsenkamer.' In spite of this, you are once again trying to enforce upon us, through a display of your power, the things that we are unwilling to do, and you are endeavoring to put us under the guardianship of a small political party which enjoys neither our confidence nor our esteem.

"Mr. Rijkscommissaris, the doctors come under your latest regulations because of the oath they have sworn when taking up their profession. It is on account of this very oath which implies certain medico-ethical standards, that it will be impossible for us in the future to comply with your wishes. Should the moment arrive that we doctors are to be faced with inacceptable demands, it may prove necessary for us to venture our lives and our freedom, and to challenge your threats.

"We hope we shall be spared such a conflict, and that we shall be allowed to continue our work conscientiously in freedom and in peace.

"Further developments in this matter depend entirely on you, Mr. Rijkscommissaris, and you will be held responsible in the presence of the Netherlands People."

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* Covering Letter for Item follows:

(COPY)

COLLEGE OF MEDICAL EVANGELISTS
Clinical Division
White Memorial Hospital
December 14, 1944

George H. Kress, M.D., Editor, addressed.
Dear Dr. Kress:

A short time ago I received a letter from one of our alumni, Dr. ————, who is on military duty and is now located in Holland. In his letter to me he enclosed a translation of a letter addressed by the Netherlands physicians to a Nazi appointed governer, and because I thought you might be interested in this document, I had my secretary make a copy, which is enclosed.

This was given to Captain ———— as a souvenir by a doctor in a little Netherlands town. It was typed and translated by one of the secretaries in the local branch of the medical society. Dr. ———— adds that the doctors eventually had things their own way and that they were the most unanimous of any group in Holland in opposing the things which the Nazis were attempting to require of them. He states: "Also, they were the only group that was able to take an open stand and not lose their necks. For this reason they were able to do much good for the people during the occupation."

If you think you can use any of this in the CALIFORNIA AND WESTERN MEDICINE, you are free to do so.

With best personal regards, I remain,

Sincerely yours,
(Signed) W. E. MACPHERSON, M.D.,
President.

December 20, 1944.

To All Members of the California Medical Association:

Dear Doctors:

I feel that you should know that Labor intends to introduce into the January session of the State Legislature a bill providing for the establishment of compulsory health insurance in California. The exact nature of this bill is not known.

Your officers of the California Medical Association have had some discussion with representatives of Labor who express willingness and indeed, eagerness, to coöperate with the doctors of California in making the most workable and least objectionable bill that can be drawn.

If the Legislature does not enact the bill into law it is understood to be the intention of Labor to take the matter to the people by the initiative in the general elections of November, 1946.

Because of the gravity of these impending events your C.M.A. Council is calling a special session of the House of Delegates to meet in Los Angeles on January 4, 1945, and the purpose of this letter is to urge you to try to attend that session. While only members of the House of Delegates may participate in the debate and actions of the House, every member of the Association is welcome to attend and I wish to urge you to do so if it is at all possible.

Your entire future may be affected by the actions taken by the C.M.A. House of Delegates in this session and it will be to the benefit of Medicine in general and to your personal benefit if you can attend and hear the matter presented and debated. I hope that you can do so.

Very truly yours,
(Signed) LOWELL S. GOIN, M.D., *President.*

Physicians Seek Place in Cabinet

An official of the American Medical Association recently declared the time has come for the medical profession to press for specific action on the creation of a national health agency "with a secretary of Cabinet rank."

Such an agency, said Dr. John H. Fitzgibbon, chairman of the A.M.A.'s council on medical service and public relations, would coördinate and administer all medical and health functions of the Federal Government exclusive of those of the Army and Navy. He said the profession long has advocated it.

(Editor's Note. In 1872 at the meeting of the American Medical Association, Dr. Thomas M. Logan who founded the California State Board of Public Health in 1870, advocated a National Health Council and in the 42nd U. S. Congress of 1872 recommended the establishment of a National Department of Health. Quotation from his statement follows: "Let us have a Secretary of Public Health, as well as a Secretary of War." For references see CALIFORNIA AND WESTERN MEDICINE, January, 1940, pages 2 and 6.)

He told the District of Columbia Medical Society formation of such an agency could be followed by discussions with the medical profession and other groups to determine "the necessity for and nature of federal action" to make high-quality medical care available to every person in the United States.

The doctor said the A.M.A. long has had the objective of the continued development of private practices, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability "including the development and extension of voluntary hospital insurance and voluntary medical insurance."—San Jose *Mercury Herald*, October 9.

Fellowships for the Training of Health Officers

The Commonwealth Fund has arranged for the training of health officers and the following conditions have been set out:

Eligibility—Length of Tenure

1. All applicants must possess a medical degree, have had at least one year's internship, and have shown ability, together with interest in and aptitude for public health.

2. Men who have had at least a few months' experience in actual public health work will be preferred.

3. Applicants without any experience in public health must have exceptional ability and if awarded a fellowship will be provided a full calendar year so that they may have opportunity for some field training either before or after their course of study.

4. Applicants who have not attended a school of public health will be preferred and the fellowships will be awarded for one school year except as indicated in number 3 above.

5. Applicants who have attended a school of public health for one year will be considered for a second year, for the doctorate, provided there are available fellowships.

6. A total of six fellowships will be available the first year.

Stipends

Single men—$175 to $200 a month, depending upon circumstances; plus tuition and travel from home to school and return.

Married men—$200 to $250 a month, depending upon individual circumstances; plus tuition and travel from home to school and return.

Procedure for Application

1. Application blanks and accompanying papers must be filed with Commonwealth Fund, which reserves the right to require personal interviews if it is deemed necessary.

2. Awards made by the fund will be subject to acceptance by the school of public health concerned.

3. Schools at which these fellowships will be tenable are:

Johns Hopkins University School of Hygiene and Public Health.

School of Public Health of the University of Michigan.

DeLamar Institute of Public Health of Columbia University.

Graduate School of Vanderbilt University.

School of Public Health of the University of North Carolina.

Physicians who are interested in the fellowships should obtain application forms from Dr. Clarence L. Scamman, the Commonwealth Fund, 41 East Fifty-seventh Street, New York 22, New York.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Blue Cross Hospitalization Growth

One of the Nation's greatest social health experiments, the Blue Cross, which is the united title for 80 American hospital care associations, passed the 15,000,000 membership mark this summer.

The Blue Cross also cleared the last barrier to admission of every American to hospital insurance. This was done by arranging for community welfare organizations to sponsor memberships for persons who lacked industrial sponsorship; employees of firms with less than 10 persons, domestic servants, the self-employed, many professional people and the retired.

The real membership this summer is nearly 16,000,000 if the count is spread to the service men and women whose enrollments are held open during the war. The rush of new members brought in almost 2,000,000 the first six months of this year. There has been no slackening since.

The Blue Cross covers 41 States and the District of Columbia. The seven States without Blue Cross service are Arkansas, Mississippi, South Carolina, Idaho, Utah, Wyoming and New Mexico.

In the Blue Cross are 3000 hospitals, which contain five-sixths of the Nation's total bed capacity for acute illnesses among the general public. Not in Blue Cross are about 2000 Federal, State, city and county hospitals, primarily for the indigent and for mental and tuberculosis cases, and about 1000 small proprietary hospitals.

There are five Blue Cross plans in Canada and one in Puerto Rico, which are counted in the American total of 80. Membership is available in areas representing about 95 per cent of the Nation's total population.

The first hospital service plan began in 1929 at Baylor University, Texas, for 1500 teachers. Inside two years there were several similar plans. Use of the name and symbol, Blue Cross, was started in 1933 by E. A. Van Steenwyk, then manager of the Minnesota plan, now executive director of the Philadelphia Blue Cross.

In the early years the main problem was actuarial, that is, whether the principle of providing hospital care for a fixed annual charge was sound, and precisely what it must cost. This hospital care is neither commercial, like life insurance, nor political like government insurance, but a cross between. It is not commercial because no profits are permitted. It is something new in large-scale American social development.

The idea of family coverage was new. Almost every-

one said it could not be done. Including maternity care was considered the rarest folly. In retrospect, the public was not particularly concerned with the price, but wanted to know whether hospital insurance was worth anything at all.

That is past. The main problem now is public relations and administration. The two combine to keep this huge, sprawling, free-will organization at an efficient and growing peak.

Letters from clients run into thousands, mainly laudatory. The common denominator of these praises is the increased sense of security.

In 1937, Julius Rosenwald of Chicago, allotted a grant of $100,000 to the American Hospital Association for study of hospital care and related problems. Afterward various Blue Cross plans, as each hospital plan is known, began to contribute to the parent body.

Now the American Hospital Association has, all from these plans, an annual budget of $70,000 for the hospital service work. Dr. C. Rufus Rorem is director of the Hospital Service Plan Commission, with headquarters in Chicago.

The hospitals in the plans report an increase in patients due to the Blue Cross movement, but without more overcrowding, because the length of stay is shorter. Blue Cross subscribers are hospitalized promptly, before they become so ill.

Women have been found to require about 50 per cent more hospitalization than men. There were 200,000 Blue Cross babies last year. Epidemics have not seriously affected the Blue Cross, although they have crowded hospitals occasionally for a month or two.

Removal of the last barrier to universal participation was typical of this voluntary social advance. It began small, scattered itself widely, and then turned into snowball proportions. One of the first community-guaranteed membership plans began in 1938 in Stillwater, Minn. Seventy-five per cent of the population joined.

Gradually this idea spread to 128 cities and towns in 20 States, with Haverhill, Mass., 46,000 population, the largest.

For its part, the Blue Cross sets up standards. These are not rules with precise limitations, but broad requirements, such as non-profit organization, assurance of good medical care, that the public interest shall be served, free choice, limitation to hospital charges and dignified promotion.

Last year the Blue Cross plans paid $70,000,000 in hospital bills, nearly 20 per cent of the income of the member hospitals. A Blue Cross member was said to enter a hospital every 20 seconds. And this was not higher than the average for all Americans. The membership then was one in every 10 Americans. Some members who had been interned in enemy territory had their hospital bills there partly paid, through an extension of benefits-wherever-you-go plans which are beginning to make headway among the associations.

Recently started is something new, medical insurance, particularly for physicians and surgeons' services in the hospitals. This movement is directly sponsored by the medical profession, but is closely coördinated with the Blue Cross. There are 14 of these medical plans in 11 States and one in Puerto Rico.

The medical plans are proceeding cautiously, sometimes having had to reorganize because there was at the start no reliable information either about costs or even what the American people would want.

The Blue Cross and the medical plans are an answer of hospital trustees and administrators, also of the medical profession, to political moves for State medicine. Many of the facts on which arguments for either system will rely are likely to come from these two experiments.—Howard W. B. Blakeslee in San Francisco *Chronicle*

American Hospital Association Plans Survey of Hospitals

Dr. A. C. Bachmeyer, director of the University of Chicago Clinics, was appointed to conduct a two-year survey of America's hospital system at the initial meeting of the Commission on Hospital Care in Philadelphia August 1. The Commission was organized on the request of members of the American Hospital Association for an independent, unbiased study to serve as a basis for plans for future hospital facilities and the extension of those already in service.

In his capacity as permanent director of study, Dr. Bachmeyer will make a survey of hospital facilities in three states—California, Michigan, and one in the South—to determine the health needs of every segment of the population, and to investigate the potentialities for an even wider distribution of hospital service.

On the basis of these studies, a nation-wide plan looking toward greater co-ordination among hospitals will be developed, aimed at extending hospital care of the sick and injured equally to all—the farmer, the laborer, the urban dweller, and those groups requiring specialized attention for mental and incurable diseases.

Dr. Thomas S. Gates, president of the University of Pennsylvania, is chairman of the Commission, which has been financed by a fund of $105,000 contributed by the Kellogg Foundation, the Commonwealth Fund of New York, and the National Foundation for Infantile Paralysis.

The Commission is composed of farm leaders, industrial and labor representatives, and members of the medical and nursing professions.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (39)

Alameda County (1)

Picard, William J., *Berkeley*

Kern County (4)

Buss, William C., *Bakersfield*
Coker, John K., *Bakersfield*
Harris, Squire O., *Bakersfield*
Maschmeyer, Joseph, *Bakersfield*

Los Angeles County (17)

Aaronson, Myer William, *Beverly Hills*
Bach, Walter L,. *Palos Verdes*
Bogue, Willis J., *Monrovia*
Brower, Arthur Benedict, *Los Angeles*
Crutcher, Roberta, *Los Angeles*
Dispensa, Johnette G., *Los Angeles*
Joesting, Harold Carl, *Los Angeles*
Linton, William Elmus, *Los Angeles*
Musser, Fred C., *Los Angeles*
Nielsen, Robert F., *Santa Monica*
Oslund, Robert M., *Los Angeles*
Shapero, Edith, *Beverly Hills*
Spomer, Isaac, *San Pedro*
Walker, Sydney, *Northridge*
Warne, Ralph Caldwell, *Los Angeles*
Weisman, Samuel, *Los Angeles*
Wical, Alfred Leslie, *Alhambra*

Orange County (3)

Newton, Raymond A., *Laguna Beach*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Specht, Oswald S., *Garden Grove*
Taylor, Irwin E., *Buena Park*

San Bernardino County (1)

Crites, A. H., *Barstow*

San Francisco County (10)

Charlier, Joseph G., *Burbank*
Engel, Samuel, *San Francisco*
Gray, Claude Cleveland, *San Francisco*
Guilfoil, James A., *San Francisco*
Halpern, Lena, *San Francisco*
Moffitt, Herbert C., Jr., *San Francisco*
Popov, Nicholas Paul, *De Ridder, Louisiana*
Sherman, George Fairchild, *San Francisco*
Siris, Evelyn Lillian, *San Francisco*
von Saltza, John W. H., *San Francisco*

Solano County (2)

Fraser, Donald A., *Vallejo*
Watson, George A., *Vallejo*

Sonoma County (1)

Testa, Dumas J., *Healdsburg*

Transfers (3)

Gries, Louis, from Los Angeles County to Solano County.
MacPherson, Douglas G., from San Francisco County to Los Angeles County.
Petty, Louise E., from Mendocino-Lake County to Alameda County.

In Memoriam

Black, Howard. Died at Palo Alto, September 21, 1944, age 70. Graduate of the Starling Medical College, Columbus, Ohio, 1896. Licensed in California in 1900. Doctor Black was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Connell, James Albert. Died at Riverside, September 24, 1944, age 65. Graduate of Northwestern University Medical School, Chicago, 1904. Licensed in California in 1920. Doctor Connell was a member of the Riverside County Medical Society, the California Medical Association, and the American Medical Association.

✤

Dunsmoor, Robert Morris. Died at Fontana, November 7, 1944, age 62. Graduate of the College of Physicians and Surgeons, Los Angeles, 1913. Licensed in California in 1913. Doctor Dunsmoor was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Hayton, Charles Henry. Died at Eagle Rock, October 9, 1944, age 75. Graduate of the George Washington University School of Medicine, Washington, D. C., 1911. Licensed in California in 1925. Doctor Hayton was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Johnson, Dwight David. Died at Grass Valley, October 30, 1944, age 85. Graduate of the New York University Medical College, New York, 1883. Licensed in California in 1893. Doctor Johnson was a Retired member of the Placer-Nevada-Sierra County Medical Society, and the California Medical Association.

Jones, Carl Power. Died at Grass Valley, October 18, 1944, age 66. Graduate of the Cooper Medical College, San Francisco, 1907. Licensed in California in 1908. Doctor Jones was a member of the Placer-Nevada-Sierra County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Lennon, Thomas Joseph. (Major) United States Army Medical Corps. Died at Hammond General Hospital, Modesto, November 13, 1944, age 48. Graduate of the University of California Medical School, Berkeley-San Francisco, 1924. Licensed in California in 1924. Doctor Lennon was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Martin, George Scott. Died at Susanville, October 8, 1944, age 58. Graduate of the University of Louisville School of Medicine, Kentucky, 1909. Licensed in California in 1920. Doctor Martin was a member of the Lassen-Plumas-Modoc County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Meininger, Leo Louis. Died at Palo Alto, October 9, 1944, age 74. Graduate of the Cooper Medical College, San Francisco, 1898. Licensed in California in 1898. Doctor Meininger was a Retired member of the San Francisco County Medical Society, and the California Medical Association.

✤

Nolan, Oscar Frederick. (Lieutenant Colonel) United States Army Medical Corps. Died at Inverness, November 12, 1944, age 44. Graduate of Baylor University, College of Medicine, Dallas, Texas, 1927. Licensed in California in 1928. Doctor Nolan was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Obando, Arcadio Tigrio. Died at Los Angeles, November 5, 1944, age 42. Graduate of Cornell University Medical College, New York, 1930. Licensed in California in 1930. Doctor Obando was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

Pallette, Edward M. Died at Chicago, Illinois, November 16, 1944, age 70. Graduate of the University of Southern California School of Medicine, Los Angeles, 1898. Licensed in California in 1899. Doctor Pallette was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Pettit, Albert Victor. Died at San Francisco, November 19, 1944, age 53. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1919. Licensed in California in 1919. Doctor Pettit was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Pidcock, Jeddiah William. Died at Los Angeles, October, 1944, age 67. Graduate of the College of Physi-

cians and Surgeons, San Francisco, 1907. Licensed in California in 1924. Doctor Pidcock was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Ryerson, Scott. Died at New York City, September 17, age 35. Graduate of the University of Buffalo School of Medicine, 1931. Licensed in California in 1933. Doctor Ryerson was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Stewart, Harry James. Died at San Diego, October 31, 1944, age 76. Graduate of Northwestern University Medical School, Chicago, 1893. Licensed in California in 1927. Doctor Stewart was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

✤

Tullar, Arthur Gilman. Died at North Hollywood, October 11, 1944, age 67. Graduate of Northwestern University Medical School, Chicago, 1906. Licensed in California in 1927. Doctor Tullar was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Correction. In the In Memoriam column of the November issue of CALIFORNIA AND WESTERN MEDICINE, on page 266, the Executive Secretary's clerk who has charge of listings of deceased members of the California Medical Association, inserted the name of William E. Waddell. This was an error. Dr. William E. Waddell of Los Angeles is still active in professional work.

OBITUARIES

Edward Marshall Pallette

1874—1944

Doctor Edward Marshall Pallette has left us. Death came to him quietly on the morning of November 16, in Chicago, where he had gone to attend a meeting of the Board of Trustees of the American Medical Association.

Following the shock of the news of his passing comes the understanding of the truth that Doctor Pallette has not really gone; more than just the memory of him remains—far more. His work, his never failing interest in the profession of medicine, his life of service to mankind, his kindliness, his untiring devotion to duties that imposed many activities—all these have left their imprint upon us—imprints that never will be erased. He remains with us.

Dr. Pallette was born in Wichita, Kan., Jan. 13, 1874. He received the Ph.B. degree from Northwestern University in 1894 and the Ph.M. in 1895. During 1894 he did investigation in the field of biology as the Oliver Marcy Scholar of Northwestern University at the Marine Biological Laboratory, Woods Hole, Mass. He received the degree of doctor of medicine from the College of Medicine of the University of Southern California in 1898 and then did graduate study in the New York Polyclinic in 1901 and in London, Vienna and Berlin at various times thereafter. He was assistant instructor of zoology at Northwestern University in 1894 and 1895, instructor in biology in the Los Angeles High School from 1896 to 1898 and at the same time instructor in histology and embryology in the College of Medicine of the University of Southern California. Following his graduation in medicine he began medical practice in Los Angeles, giving special attention to gynecology. He was associated with the health department of Los Angeles as assistant health officer from 1898 to 1899 and as a member of the Los Angeles County Board of Health from 1905 to 1906. He taught physiology in the College of Dentistry of the University of Southern California from 1900 to 1912 and was a lecturer in obstetrics and gynecology in the Training School for Nurses of St. Vincent's Hospital.

As a distinguished citizen of the State of California he held many special appointments, including examiner for the California State Lunacy Commission from 1905 to 1915, membership on the California State Board of Public Health from 1932 to 1940 and member of the Retirement Board of the Los Angeles City Schools from 1938 to 1939. Since 1938 he had served also as treasurer and member of the Board of Directors of the Blue Cross Plan known as the Hospital Service of Southern California.

During World I, Dr. Pallette served as a captain in the medical corps, acting as surgeon in the Letterman General Hospital at the Presidio in San Francisco and also at Camp Crane in Allentown, Pa. In the present war, since June 1, 1942, he acted as chairman of the Procurement and Assignment Service for Physicians of the War Manpower Commission in Southern California. His interest in general education was exemplified by his membership on the Medical School Advisory Committee of the University of Southern California and the presidency of the Los Angeles County Board of Education.

In the work of the American Medical Association, Dr. Pallette gave also fully of himself for the advancement of the medical profession. He was a member of the House of Delegates in 1933, 1935, 1936 and for the period 1938-1942. In 1942, he was elected a member of the Board of Trustees of the American Medical Association. He was a member of the California State Medical Association and its president in 1936-1937. He was also a former president of the Los Angeles County Medical Association. His membership in special societies included fellowship in the American College of Surgeons, membership in the Los Angeles Surgical Society, the Los Angeles Obstetrical and Gynecological Society, the Los Angeles Academy of Medicine, the Hollywood Academy of Medicine, the Institute of American Genealogy and the American Association for the Advancement of

Science. Of many of these groups he had been president.

In the death of Dr. Pallette, the American Medical Association lost a loyal and distinguished counselor, a self-sacrificing and devoted member of its Board of Trustees.

Surviving Doctor Pallette are Mrs. Elizabeth Brown Pallette; three sons, Lt. Col. Edward C. Pallette, Warren S. Pallette and Drew B. Pallette; and a daughter, Elizabeth D. Pallette.

Funeral services were held Wednesday morning, November 22, at St. Paul's Cathedral, Los Angeles.

Active pall bearers were: Messrs. Owen Brower, Earl Kennick, Andrew Brown, Lawrence Hall, Oscar Trippet and Dr. John Martin Askey.

Honorary pall bearers were: Drs. C. G. Toland, Wm. H. Kiger, Edwin O. Palmer, Egerton L. Crispin, B. O. Raulston, James F. Percy, E. Vincent Askey, George Denhart, C. W. Bonynge, Rufus B. von KleinSmid, Oscar Lawler, Frank Barham, A. J. Scholl, Thomas Chalmers Myers, Francis L. Anton, Roy W. Hammack, Lowell S. Goin, L. A. Alesen, E. T. Remmen, Wayland Morrison, John B. Doyle, William R. Molony, Arthur S. Granger, William H. Daniel, Charles T. Sturgeon, Maurice Kahn and Edward F. Schewe; and Messrs. Howard Burrell, Nathan Newby, Sr., Barry Hillard, Paul Mattoon, Dwight L. Clarke, Colin Gair, Cassius M. Jay, Ritz E. Heerman, and S. K. Cochems.*

✤

Carl Power Jones

1878—1944

Dr. Carl Power Jones was born in Grass Valley—the son of Dr. and Mrs. W. C. Jones. Since 1875, a period of almost seventy years, the family of Dr. Carl Power Jones has furnished outstanding members of the Medical Profession of Nevada County. His death closes this long term of medical service begun by his father, the late Dr. W. C. Jones, and carried on by Carl and his brothers, the late William and John Jones.

Following his graduation from Cooper Medical College Carl Jones interned at St. Lukes and at the old City and County Hospital. Since 1907, when he opened his office, in partnership with his brother John, Dr. Carl had practiced continuously in Grass Valley, except for a period of service as Lieutenant-Commander in the United States Navy in 1917-18. He had been an honored member of the Placer-Nevada-Sierra County Medical Society for thirty-seven years—one of the oldest members in point of years of service.

Carl Jones was one of the outstanding surgeons of Northern California—an ethical practitioner, who gave liberally of his time, his talents and his resources for the promotion of the health of the community and for the betterment of the health of his patients. A brief article concerning Grass Valley $700,000 Postwar Hospital, of which Dr. Jones was the indirect sponsor, appeared in CALIFORNIA AND WESTERN MEDICINE, for September, on page 174.

Carl Jones was a man of many and varied interests. He was an enthusiastic sportsman, interested in fine horses and in aviation, a gold-mining owner and promoter, with an abiding faith in the mining future of the Grass Valley District, and an earnest worker in every movement for the improvement of his City and County. But, first and foremost, he was a capable and honest practitioner of the healing art in which he was extraordinarily successful.

Carl Jones liked people and people liked Carl Jones. His sudden death on October 18, 1944, removed from Grass Valley and from Nevada County a beloved figure who was the friend, counsellor and physician of members of three generations, to whom his passing assumed the proportions of a calamity.

* For editorial comment, see page 279.

George Scott Martin

1885—1944

George Scott Martin died at his home in Susanville, California, on Sunday, October 8, 1944, of coronary occlusion, at the age of 58. He was a native of Dallas, Texas. Graduated in 1909 from the University of Louisville Medical School, Louisville, Kentucky. He was first honor student all four years, and served his internship in the Louisville City Hospital. Later he practiced medicine in Dallas, Texas, and Phoenix, Arizona. In World War I, Dr. Martin served in France and England with the rank of Major. He located in Susanville, California, in 1920, where he built Riverside Hospital, which he owned until August, 1944.

Dr. Martin was Past Master Blue Lodge in Arizona; 32nd degree Mason; held prominent posts in Masonic bodies. Was a member of the American Association of Industrial Physicians and Surgeons; City Health Officer of Susanville, and Physician and Surgeon for the Southern Pacific Railroad in Susanville.

U. S. Casualties Near Half Million

Washington, Nov. 2.—American casualties in excess of half a million for the first three years of the war were indicated today in official Army and Navy statements.

Casualties to date include more than 110,000 dead, and approximately 260,000 wounded, 67,000 missing and 58,000 prisoners of war.

The nineteen months of World War I cost the United States about 318,000 casualties, including about 50,000 killed.

In the two years and eleven months of the present war, United States Army dead alone totaled more than 80,000, and in addition, nearly 30,000 members of the naval service and merchant marine have been killed.

Army casualties in all theaters now total more than 420 000.

These include 417,121 casualties reported to the War Department up to October 21, and 3,221 casualties sustained in the invasion of the Philippines up to October 31.

The *War Department's* totals as of October 21 are as follows:

Killed, 80,666; wounded, 229,212; missing, 53,622; prisoners of war, 53,621. Of the wounded, 105,449 have returned to duty.

Casualties in the Leyte operation, as announced by Gen. Douglas MacArthur, included 706 killed, 270 missing, and 2,245 wounded.

The War Department figures, of course, do not include casualties suffered in France, Italy or elsewhere since October 21.

Of the 81,000 American soldiers killed thus far in the war, approximately 50,000 gave their lives in the European phases of the war, including the north African invasion, and the Italian and French campaigns.

Approximately 30 000 Americans have been killed in France, 17,000 in Italy, and 2,500 were killed in North Africa and Tunisia. The remaining 31,000 have been killed in various Pacific campaigns.

The *Navy Department* tonight announced that casualties in the naval service so far notified to next of kin total 70,571, including 28,231 killed, 28,441 wounded, 9,421 missing, and 4,478 prisoners of war. These figures do not include naval casualties sustained in the last week's sea-air battle of the Philippines.

Diokles of Carystos (*ca.* 300 B. C.) wrote the first book on anatomy describing the lungs, heart, gallbladder, ileocecal valve, ureters, ovaries and tubes. He discovered the *"Punctum Saliens."*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in Philadelphia, June 18-22, 1945. (*J.A.M.A.*, Nov. 25, 1944, p. 843.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In December, KFAC will present these broadcasts on the following Saturdays: December 2, 9, 16, 23, and 30.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Interesting and Amusing:* Be sure to read G. W. Corner's *Ourselves Unborn: An Embryologist's Essay on Man* (Yale Press, New Haven, Conn., 1944, $3), the best Terry Lecture in years, wise, witty and well-done. Enjoy A. E. Hertzler's *Ventures in Science of a Country Surgeon* (privately printed, Halstead, Kansas, 1944), clear, colorful and courageous, with Ray Allen's foreword stressing Hertzler's thesis that the good doctor is a student always. Get R. M. Wilson's *British Medicine* (Britain in Pictures series, Hastings House, N. Y., 1944, $1.25) if for nothing else than its fine illustrations. Note National Music Council (338 W. 89th St., N. Y. 24) reports on use of music in hospitals for mental and nervous diseases.

2. *To Think About:* Excellent recommendations for the *National Medical Library* in survey of Army Medical Library by K. D. Metcalf & Co. (Am. Lib. Asso., Chicago, 1944). Q. Wright's homily on freedom in universities (*A.A.U.P. Bull.*, 30:167, 1944), neglects to mention significance of personal responsibility in justifying freedom. H. T. Houf discusses the ideal University president, noting importance of unselfishness (ibid., p. 277). J. K. Wright reports on human nature in science (*Science*, 100:299, Oct. 6, 1944). Nursing Information Bureau of American Nurses' Asso. issues *Facts About Nursing*, 1944 (1790 Broadway, N. Y. 19). Better write for a copy!

3. *Books to Get:* Edwards Bros., Ann Arbor, Mich., will issue the S. C. Brooks' long awaited monograph on permeability, about which they had such trouble abroad and at home. Also from Edwards Bros.: H. Buscher on pathology and therapy of chemical warfare injuries ($4); C. A. O. Franz on military surgery ($13); K. Hinsberg's Geschwulstproblem in Chemie and Physiologie ($8.25), and F. Kauffmann on the bacteriology of the salmonella organisms ($7). For popular use it's hard to beat E. W. Hayes' *Tuberculosis As It Comes and Goes* (privately printed, Monrovia, Calif., 1943). G. Hosford recommends S. A. Fox's *Your Eyes* (Knopf, N. Y., 1944, $3). Genial Manchester historian (medical), E. M. Brockbank offers neat biography of John Dalton and account of his theory of colour vision (Manchester Univ. Press, 1944, $2). R. A. Moore writes a new *Pathology* (Saunders, Phila., 1944). A. R. Rich's *Pathogenesis of Tuberculosis* looks like a honey (C. C. Thomas, Springfield, Ill., 1944, $10.50). E. F. Burton offers *The Electron Microscope* (Reinhold, N. Y., 1944, $3.85). Harvey Cushing's Visit to *Le Puy-en-Velay* appears with notes by John Fulton (Rowfant Club, Cleveland 15, $8). Get R. J. Behan's *Pain: Its Origin, Conduction, Perception and Diagnos-Significance* (Appleton, N. Y., 1944). Important is W. R. Bloor's *Biochemistry of the Fatty Acids* (Reinhold, N. Y., 1944, $6). R. A. Sawyer's *Experimental Spectroscopy* looks tops (Prentice-Hall, N. Y., 1944, $3.75). W. W. Babcock offers *Principles and Practice of Surgery* (Lea & Febiger, Phila., 1944, $12). R. S. Harris and K. V. Thimann survey *Vitamins and Hor-*

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

mones (Academic Press, N. Y., 1944, $6.80). G. Seifer's *Virus Diseases in Man, Animal and Plant* is O.K. (Philosophical Lib., N. Y., 1944, $5). Interesting is W. F. Norwood's *Medical Education in the U. S. Before the Civil War* (Univ. Penn. Press, Phila., 1944, $6). Outstanding is S. Bunnell's *Surgery of the Hand* (Lippincott, Phila., 1944, $12). See F. D. Murphy's *Acute Medical Disorders* (Davis, Phila., 1944, $6). J. Dollard & Co. (Yale) study *Frustration and Aggression* (Kegan Paul, Lond., 1944, $3). L. R. Broster undertakes *A Study in the Surgery of Sex* (Heineman, Lond., 1944, $5).

4. *Antibiotics:* E. S. Duthie describes production of penicillinase by organisms of subtilis group (*Brit. J. Exp. Path.*, 25:96, 1944). G. Soo Hoo and R. J. Schnitzer note that penicillin synergizes with sulfonamides but not with acridines (*Arch. Biochem.*, 5:99, 1944). M. R. Lewis observes that while impure penicillin may damage sarcomatous cells, pure penicillin will not (*Science*, 100:314, Oct. 6, 1944). A. E. Francis and Co. find definitely that patulin has no value in common cold (*Lancet*, 2:370, Sept. 16, 1944). J. W. Bigger notes that penicillin is inactivated by blood and serum (*Lancet*, 2:400, Sept. 24, 1944). C. J. Cavallito and J. H. Bailey report that cysteine and esters, but not other SH cmpds. inactivate penicillin, citrinin, clavacin, pyocyanine, and new antibiotic from allium sativum (*Science*, 100, 390, Oct. 27, 1944). Note on same page G. Schwartzman's cellophane method for growing penicillin.

Stanford President Talks to A.A.M.C.—The major problem facing medical education today is a reconsideration of the entire teaching program to determine what to eliminate and what to add, Donald B. Tresidder, M.D., president of Stanford University, declared on October 24, at a meeting in Detroit of the American Association of Medical Colleges.

Stressing the fact that an accelerated teaching program now in operation is inevitable in wartime to meet a critical shortage of doctors, Dr. Tresidder suggested that the important issue to consider is "an analysis of the degree of competence we want developed in the medical profession, and the means of developing it."

A total of $34,000 in War Bonds as prizes for the best art works by physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty" (in war and in peace) has been announced.

This prize contest is open to any physician member of the American Physicians Art Association, including medical officers in the Armed Forces of the United States and Canada.

Full information available on request of the sponsor, Mead Johnson & Co., Evansville, Ind., U.S.A.

Doctors Term Carrying Baby 18 Years Rarity.—Southern California medical circles last month buzzed with discussion of the disclosure that Mrs. Martin Buck, 56, a visitor in Valyermo in the South Antelope Valley, had carried an unborn baby for 18 years.

"Rarer than quadruplets," "once in a million," "extremely unusual" ran the comments on how Dr. H. H. Snook had performed the operation in his Palmdale Hospital.

Learning of the primary abdominal pregnancy in which an operation similar to a Caesarean section was used to remove the mummified body of the baby, Dr. Burrell O. Raulston, dean of the University of Southern California School of Medicine, said, "It is one of the rarest complications that accompany pregnancy and childbirth."

Dr. Raulston said obstetricians on the S. C. faculty reported such an instance occurs perhaps once in a million times.

Dr. Walter E. Macpherson, president of the College of Medical Evangelists, said this institution is especially curious about the strange case because Dr. Snook is one of its graduates.

Although Mrs. Buck first felt apparent labor pains after carrying the child for eight months in her home at Bonnerdale, Ark., she dismissed the symptoms as a tumor when no baby appeared. Not until last month, when she first called on Dr. Snook to treat a severe cold, were x-rays used to discover the amazing rarity.

Dr. Macpherson said his associates found, in a possibly incomplete search, only five authentic reported cases of similar character. Two such extra-uterine cases lasted for 46 years each, one 23 years and one 10 years.

"About one of every 4,800 of these ectopic embryos is normal at all and only one of every 480,000 lives to any length of time within the body of the mother," the medical college president said.

"For rarity, this may be compared with quadruplets, which occur only once in every 400,000 births."—Los Angeles *Times*, November 30.

Honors to Dr. J. C. Geiger, Director of Public Health, City and County of San Francisco.—On August 23, 1944, the Faculty of Medicine, the University Senate and the Board of Administrators of Tulane University of Louisiana, requested Dr. J. C. Geiger to make the Commencement address at its largest Commencement ever to be held, on October 14, 1944, in New Orleans, Louisiana.

At that time the honorary degree of Doctor of Science was conferred upon him, this being the second honorary degree to be so received from this University. The current citation is as follows: "A noted epidemiologist, a medical officer of health and author of excellence, and Tulane's most distinguished alumnus."

American College of Radiology.—Lt. Comdr. L. Henry Garland (MC), U.S.N.R., formerly of San Francisco, now stationed at the U. S. Naval Hospital, Astoria, Oregon, has been elected a member of the American Board of Radiology, according to a recent announcement by the Radiological Society of North America. Doctor Garland was elected to the examining board by the Radiological Society to serve as one of its representatives for a six-year term.

Military Order of the World Wars.—Cornelius O. Bailey, M.D., Major, U. S. Army, Medical Corps, World War I, has been notified of his reëlection as Surgeon General of the Military Order of the World Wars, at their National Convention, held in September, at Atlanta, Georgia.

Thomas Carlyle (1795-1881).—The physical armor of Carlyle was invulnerable to serious illness, but the hardships of his youth left him a chronic dyspeptic. His sufferings undoubtedly were real enough, yet his imagination, aided by the result of self-medication with copious quantities of castor oil, magnified his troubles a hundredfold. Extremely exacting, and often carping in his views of men and events, Carlyle has been held up as another example of genius and bad digestion going hand in hand. —Warner's *Calendar of Medical History.*

Cold Vaccines of Doubtful Value.—Vaccines popularly supposed to prevent or cure the common cold were condemned on November 30 as having no proved value.

The joint report by the A.M.A. Councils on Pharmacy and Chemistry, and Industrial Health, included vaccines administered hypodermically, by swallowing capsules

(oral vaccine), and by local spraying of the upper respiratory tract.

"Decisive evidence of the value of any vaccine is not forthcoming, and the weight of careful studies clearly indicates that none of the vaccines now available when administered by the routes advised have proved of value," the report said.

"Vaccines for colds can not be recommended for routine administration to industrial groups or to individuals."

Correction.—In the In Memoriam column of the November issue of CALIFORNIA AND WESTERN MEDICINE, on page 266, the Executive Secretary's clerk who has charge of listings of deceased members of the California Medical Association, inserted the name of William E. Waddell. This was an error. Dr. William E. Waddell of Los Angeles is still active in professional work.

Medical Test for All Argentine Citizens.—A new government decree requiring periodic medical examination for all Argentines was announced by the Argentine Government on December 3.

Wisconsin Vitamin Patents Held Invalid by U. S. Court.—The valuable Steenbock patents for food irradiation, held by the Wisconsin Alumni Research Foundation, were for the second time held invalid on November 24 by the Ninth Federal Circuit Court of Appeals. Winner by the decision is Vitamin Technologists, Inc., a Los Angeles concern.

This time the court described the patent—which has been netting the Wisconsin Foundation nearly a million dollars a year for scientific research—as a "profit-controlled monopoly barrier." . . .

Judge William Denman, who wrote this opinion, said: "The evidence and appellee's brief are replete with well-verified statements of the great boon to humanity of Dr. Steenbock's scientific discoveries for the prevention and cure of rickets. The truth of such statements make stronger the contention that it is a public offense to withhold such processes from any of the principal foods of the rachitic poor."

The court did not invalidate the patent on the ground of public interest, however, but mainly on the premise that the principle of improving certain food substances by exposing them to ultraviolet rays, from sun or lamp, was not a new one.

New Hospital at Lynwood in Los Angeles County.—Construction of the new $600,000 St. Francis Hospital at Imperial and Century Boulevards started on November 21, according to Rt. Rev. Msgr. Thomas J. O'Dwyer, director of the Catholic Charities, sponsors of the project.

No definite completion date has been set, but it is hoped by Msgr. O'Dwyer that formal dedication services can be held on or before July 1.

The initial structure will provide for 100 beds, but construction of a maternity wing and facilities for additional general wards are already contemplated.

It is pointed out by Msgr. O'Dwyer that at least 500 more hospital beds are needed in this area to bring it up to the national average. Acuteness of the local hospital situation, he said, prompted Congress to appropriate $400,000 of Lanham Act funds for the structure. An additional $200,000 for fixtures, equipment and furnishings is being raised here and in surrounding communities by public subscription.

The new hospital will be equipped with the latest clinical laboratory and surgical innovations and its facilities will be available to all, regardless of race or creed.

California 1950 Population May Be Second Largest.—California is looking forward to the privileges—and headaches—connected with becoming the State with the second largest population in the country.

Governor Warren has put it this way:

"California has passed Ohio and Illinois to rank third among States in population. With the postwar industrial and construction program now being formulated, we should overcome Pennsylvania's lead of about 1,000,000 by 1950."

Colonel Alexander Heron, state director of reconstruction and reëmployment, also looking six years ahead, says:

"California will retain all but one-fourth or one-fifth of its wartime migrants and will have a population of 8,500,000 to 9,000 000 by 1950."

A general study of the population status, supervised by Colonel Heron, says:

"Between April, 1940, and January, 1944, the war transformed our State. In that three and a half year period, California acquired factories and plants turning out untold quantities of war materials, was crossed and recrossed by countless transient military and civilian personnel on urgent war business, served as a jumping off place for men and materials for one of the great war efforts, and harbored military installations of unprecedented magnitude.

"In the process, the State acquired an extra million and a half people who had not lived here before. a jump from slightly under 7,000,000 to almost 8,500,000. Of these, 1,320,000 were migrants from other States who came to work in the war industries or for other reasons moved to California. The rest were babies born here.

"The two increases, 'natural' increase and increase by migration, broke a number of records. They constituted the greatest numerical increase of any State for the same period. California by-passed Ohio and Illinois to become the third most populous state in the union, exceeded only by New York and Pennsylvania. And in the single year 1943 the rate of population growth—600 000 per year—was the most phenomenal ever recorded by any one of the United States."

Doctors Assert Vitamin Tests Prove Negative.—Physicians who conducted a 30-day vitamin-feeding experiment with 200 persons, at the Army's request, on November 23 reported the "administration of vitamin supplements to a group of apparently normal persons, consuming the usual American diet, had no demonstrable beneficial effect."

The study was made at Duke University School of Medicine at the request of the quartermaster general's office.

The authors, Dr. Julian M. Ruffin and Dr. David Cayer of Durham, N. C., said:

"At present the use of vitamins is widespread throughout the country, not only in the treatment of disease, but also by apparently normal persons.

"While no one would question the employment of vitamin therapy in frank deficiency disease, or even in suspected deficiency states, still one wonders if the indiscriminate use of vitamins, sold over the counter to people who have no obvious disease, is justified.

"It has been implied that, even when no demonstrable deficiency exists, one's sense of well being and ability to perform work can be improved greatly by the addition of vitamins to the diet.

"As pointed out by the Council on Food and Nutrition and on Industrial Health (of the American Medical Association) there is at present no conclusive evidence to substantiate this point of view."

Cadet Nurse Residence Dedication Rites Held.—The new U. S. Cadet Nurse Corps residence at the California Hospital School of Nursing, in Los Angeles, was dedicated on October 29, with F. C. Noel, president of the board of directors, accepting Moore Hall as the new home of trainee nurses.

The residence is named in honor of the late Dr. E. C. Moore, who was connected with the California Hospital many years before his death last July.

The building was acquired under the Federal Works Agency and was presented to Noel by Wright L. Felt, regional engineer of the Federal Works Agency.

Bicknell Building of California Hospital in Los Angeles to Be Opened Soon.—Remodeling of the Bicknell Building, which will provide an additional 110 beds for patients, as an annex to the main building of the California Hospital, is rapidly nearing completion. This project is a Federal Works Agency Grant-in-aid program in line with the government's campaign to utilize existing facilities in an effort to increase the number of hospital beds in Los Angeles area, where an acute shortage exists.

An additional 120 employees will be needed to adequately staff departments which will be affected by the increased patient load. The War Manpower Commission has provided the hospital with a special manpower priority and a recruitment program is now in progress. An additional 24 graduate nurses and 24 nurse attendants will be required to provide bedside care for the patients when the new unit is filled to capacity. Special emphasis is being placed upon this phase of the recruitment program, due to the present shortage of nurses in this area.

The building has been equipped with new furniture and modern facilities. The unit will consist largely of ward accommodations.

The new addition will give the California Hospital a total capacity of 411 adult beds and 48 bassinets.

Robert A. Peers in Practice for 45 Years.—Recently Doctor Robert A. Peers, Medical Director of the Colfax School for the Tuberculous, completed his 45th year of practice in Colfax in Auburn County. His many friends took occasion to send him congratulations. Doctor Peers was president of the California Medical Association in 1935.

Governor Warren Urges State Control of All Hospitals.—Gov. Warren on November 27 requested Dr. Wilton L. Halverson, director of public health, to draft legislation which, if enacted, would place all hospitals in the State under control of a State agency.

Dr. Halverson reported that "it is easy to start up a hospital now because there are no State licensing laws," and said that as a result "some institutions are not giving good service."

"Probably some deaths have occurred which could have been prevented by proper care," Dr. Halverson said.

Dr. Halverson and Charles M. Wollenberg, director of social welfare, told the Governor's council meeting that they had agreed jurisdiction over county hospitals, now under the Welfare Department, should be transferred to the Health Department.

Director Wollenberg said surveys made by members of his staff showed "most county hospitals are not good."

Diploma Mills of California.—For many years, in California, all that was necessary to secure incorporation papers for institutions of learning having authority to grant degrees, was to make application to the Secretary of State, in much the same manner in which a business group incorporates.

It was during those years that a considerable number of fly-by-night educational institutions came into existence. Subsequently a law was enacted requiring evidence of material and other resources before incorporation of an institution of learning, having power to grant degrees, could be granted. In connection with the above, the *J.A.M.A.* for November 4, 1944, on page 648, prints an item, "Another Diploma Mill," in which are mentioned the following institutions: "White Cross Medical College of the University of Physicians and Surgeons of Southern California"; "Extension Branch of the Los Angeles University, College of Psychiatry"; and "Golden State University of Los Angeles."

The item relates that the New York County Grand Jury on October 10th took steps to bring to task a promoter who was using the names of the above institutions.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Sacramento Doctors to Quit License Fight

Sacramento Society for Medical Improvement probably will not carry out its threat to take legal action to prevent the City from levying a license fee on doctors, Dr. Wayne Pollock, president of the society, said on October 30.

He said, however, that attorneys for the organization are still studying the matter.

The new business license ordinance, which went into effect after a petition for a referendum vote failed last week, levies an annual fee of $24 on doctors.

Before it was adopted by the City Council, the Society for Medical Improvement fought the measure on grounds that it was indirectly "a tax on sick people."—Sacramento *Union*, October 31.

New Concession Given British Soldiers Wishing to be Fathers

Cairo, Africa. (U.P.)—The British army committee on compassionate posting—better known as the baby leave committee—made another concession to the thousands of Tommies in the Middle East who are anxious to return home and become fathers after years of service in the desert.

The committee is composed of five officers and five enlisted men, with a lieutenant colonel as chairman. All are anonymous. The chairman recently announced that high priority will be extended to soldiers who could have fathered babies if they had wanted to before the war, but didn't. Previous preference had been given soldiers now medically able to procreate, but who hadn't been before being shipped to the Middle East.

Government authorities here deplored the publicity given the baby leave committee among troops in this theater, resulting in the committee being inundated with applications. There isn't enough shipping space to accommodate the flood of applicants, and they will have to take their turn. . . . —Samuel Souki in Los Angeles *Times*.

U. of Texas President Is Discharged

Houston, Texas, Nov. 1 (UP.)—Dr. Homer P. Rainey, president of the University of Texas, has been discharged and three members of the Board of Regents have resigned, it was announced tonight after the regents ended a closed session at the Rice Hotel here.

Announcement of the discharge of President Rainey was made by Leo P. Haynes, secretary of the board. (Note. For other items, see in CALIFORNIA AND WESTERN MEDICINE, for November, on page 269.)—San Francisco *Chronicle*, November 2.

San Francisco Health Director Honored

Dr. Geiger Addresses Tulane Graduates

San Francisco and its Department of Public Health won acclaim yesterday when Dr. J. C. Geiger, City Health Director, presented the commencement address at Tulane University of Louisiana at New Orleans.

Not only was Dr. Geiger honored as the main speaker

of the day, but he also had the honorary degree of Doctor of Science conferred upon him—his second honorary degree from Tulane. In his career as city health officer of San Francisco he has received seven honorary degrees from various universities.

Dr. Geiger was given the degree with the citation: "A noted epidemiologist, a medical officer of health and author of excellence, and Tulane's most distinguished alumnus."

For his study and research on the subject of epidemics and the control of disease in crowded areas, Dr. Geiger—according to faculty members of the institution—has been placed among a galaxy of notable medical men of the Southern States.

A special reception for the city health officer and Mrs. Geiger was held on the Tulane campus Friday, followed by a ceremony in which a graduate student was awarded the Geiger medal—a scholarship award which was established many years ago by the earlier members of the doctor's family.

The medal and scholarship are awarded each year to a graduate student winning a degree of Doctor of Philosophy for a thesis of original research work on a public health problem of interest to the Southern States or Central American countries. Many students who have later become famous physicians have received this award and their research works have been published throughout the country.

Dr. Geiger's commencement address was entitled, "The Health Department of the Future—a Discussion of Some Problems."

In his talk Dr. Geiger said he believed the accelerated treatments for gonorrhea and syphilis with sulpha drugs and penicillin had proved "ineffective generally" in many cases, but that progress had been made.

"It is felt that the so-called rapid treatment is only effective in 50 per cent of the cases treated, and that the one-day penicillin gonorrhea treatment is effective in only 70 per cent of the cases," he said.

"The newly devised 10-week treatment for syphilis is relatively safe therapeutically and efficient in the treatment," he added.—San Francisco *Chronicle*, October 15.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Regulation of Medical Staff By Private Hospital

From time to time the question has arisen as to the right of a private hospital to bar a particular physician from the use of its facilities. We will set forth herein the general rules governing the regulation of the staff of a hospital.

The principle is set forth in *30 Corpus Juris* at page *463* that "a hospital may prescribe reasonable rules concerning the qualifications of physicians allowed to practice in the hospital. The governing body of a hospital may refuse to permit physicians professing a certain system of medicine to practice in the hospital, adopt such regulations as are proper or deemed by it necessary or expedient to improve the hospital, . . ." and it is stated in an annotation on this subject in *60 A.L.R.* at page *656:*

"Although there are comparatively few cases on the subject under annotation, it seems to be the practically unanimous opinion that private hospitals have the right to exclude licensed physicians from the use of the hospital, and that such exclusion rests within the sound discretion of the managing authorities."

It is apparent that the same rule is applied to private hospitals as to membership in associations such as the California Medical Association or the local county medical societies. A private hospital, just as the members of such an association, have a right to govern their internal affairs without interference so long as their actions are reasonable and in accordance with the by-laws, articles of incorporation or other instrument regulating their operation.

There has been, however, considerable litigation over the right of a hospital to exclude a licensed physician from the use of the hospital.

In *Hughes v. Good Samaritan Hospital, et al.* (Ky. January 16, 1942) 158 S.W. (2d) 159, the superintendent of the defendant hospital ruled that it would be necessary for the plaintiff to have the endorsement of the proper board of officers of the American College of Surgeons before he would be permitted to use the surgery room. The plaintiff was a licensed physician who had had a successful practice and apparently his ability as a surgeon was unquestioned. The court found that the underlying reason for denying the use of the operating room to plaintiff was that he had "invaded the field of the specialist" by performing certain operations which are usually performed by specialists. The court held that this private hospital had the right to exclude a licensed physician from the use of the hospital and that such exclusion rested within the discretion of the managing authorities. It was said that the plaintiff had no vested right to practice in the hospital's operating room notwithstanding the fact that he was a competent and qualified surgeon. The opinion rendered quoted with approval from the case of *Van Campen v. Olean General Hospital,* 205 N.Y.S. 554.

In the latter case the defendant hospital was a membership corporation of which the plaintiff, a licensed physician, was a member. For a time he was on the staff of the hospital. Because of "petty" differences between the plaintiff and the members of the staff he was dropped from the staff by action of the board of directors, and the privilege of treating patients in the hospital was refused him. It was held that the court would not interfere with the action of the board of directors as they had a wide discretion in determining the policy of the corporation and, in the absence of fraud or bad faith, the courts will not interfere. It was said "another by-law provides that, if the board of directors shall determine that the character, conduct or acts of any member of the medical staff are such as to interfere with the orderly conduct of the hospital, the board may by resolution remove or suspend him. There is no provision in the by-laws for a hearing prior to removal or suspension. We think none is required. The selection and retention of physicians to treat patients admitted to the hospital are matters of judgment and discipline. The power to appoint usually implies the authority to remove."

In *Harris v. Thomas* (Texas, 1920) 217 S.W. 1068, the defendant hospital appointed a committee to reorganize it and to select members of the staff. The plaintiff, an osteopath, who had practiced for a number of years and used the facilities of the hospital, was not named as a member. The Court in refusing the plaintiff relief said:

"We believe it to be the right of the sanitarium to refuse business relation with appellant, if it sees proper to do so, and also to adopt such regulations as are proper or deemed by it necessary or expedient to improve its efficiency and standards of service. . ."

One limitation upon the rights of a private hospital is the fact that certain emergency cases must be admitted without regard to the attending physician. This phase of the problem will be considered in the next issue of this column.

Irrigation of the bladder in renal colic, cystitis and gonorrhea was employed with gratifying results by John of Arderne (1306-1390).

Antonio Musa Brassavola, of Ferrara (1500-1555), who was the first of his time to reintroduce tracheotomy, wrote extensively on the subject of syphilis.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL
Vol. XVII, No. 12, December, 1919

EXCERPTS FROM EDITORIAL NOTES

The Drug Addict Question.—Recognition of the evils and wide distribution of drug addiction has advanced to the point where we are witnessing various governmental efforts to control the use of habit-forming drugs. That these efforts have not met with adequate success is demonstrated by the problems now appearing of the care and criminality of drug addicts who are hampered under the law in procuring a sufficient supply of the drug to keep them comfortable, law-abiding and productive workers. Illicit drug dealers are profiteering to a huge extent among these unfortunates and thus creating a situation still further operating to cause criminality, suffering and social inefficiency. . . .

Minimum Wage for Office Workers.—The State Industrial Welfare Commission, under date of June 20, 1919, issued an order affecting the minimum wage lawful to be paid women and minors. This is set at $13.50 per week, and includes workers in professional offices. The only exceptions to this rule apply to learners who, under certain conditions, may receive smaller wages. The total proportion of learners to all women employed shall not be greater than 33 1/3 per cent. . . .

Physicians should take due notice of this order and govern themselves accordingly.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Notes on Encephalitis Lethargica in San Francisco," by Philip King Brown, San Francisco.—Encephalitis Lethargica has made its appearance on the Pacific Coast in numbers sufficient to emphasize the epidemic character of the disease, and in a guise that frequently detracts attention from the chief characteristics of the disease as thus far described. . . .

From an Article on "Intestinal Flagellates: A Plea for Their Pathogenicity," by John V. Barrow, S.B., M.D., Los Angeles.—A general survey of the literature on flagellated protozoa impresses one with their growing importance. Twenty years ago, they were reported in different human organs as a sort of curiosity, but scarcely to be thought of as pathogenic parasites. However, very recent years have brought a greater realization of their importance as producers of pathology. The amoeba and ciliated balantidium coli were first to gain recognition. Now they have a young army of medical men ready to respect their pathogenic power. What has happened in the rôle of the amoeba, and balantidium, is beginning to be realized in the case of the flagellated monads. . . .

From an Article on "A Plea for the Earlier Recognition of Subacute Infantile Scurvy," by Langley Porter, M.D., M.R.C.S. (Eng.), San Francisco, and W. E. Carter, M.D., Los Angeles.—It is a popular lay notion which unfortunately has found its way into the medical mind

(Continued in Front Advertising Section, on Page 12)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is honed that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.,
Secretary-Treasurer

News

Board Continues Doctor's Plea

Sacramento (AP.)—The State Board of Medical Examiners last night continued until March action on the application of Nathan S. Housman, former San Francisco physician, for restoration of his medical license.

Housman's license was revoked by the board after he was convicted of keeping improper narcotic records and of perjury in his testimony at the trial.

The board placed on probation for a year Dr. Edward M. Lundegaard, Oakland, who was charged with aiding unlicensed persons in operation of a treatment for alcoholism.—Vallejo *Times Herald*, October 19.

"Opportunity Open to Foreign Physicians: The San Francisco Committee for Service to Émigrés has been informed by the National Committee for Resettlement of Foreign Physicians that the United Nations Relief and Rehabilitation Administration is in need of physicans from all branches of medicine. The age limit is 55 years. United States licensure is not essential. Germans, Hungarians, Bulgarians and Austrians, who are not yet American citizens, are not eligible, although unusually well qualified Austrians may be considered. Nationals of non-Axis countries are eligible. Time spent in the employ of the United Nations Relief and Rehabilitation Administration (UNRRA) overseas will not be deducted from the required period of U. S. residency in computing eligibility for U. S. citizenship. Amercan citizens are, of course, eligible. The salary ranges from $3 200 to $7.000 a year, plus total maintenance on a per diem basis. (Anyone interested may receive further information by telephoning Miss Schoenholz at Fillmore 4513.)" (From *Emanu-El Jewish Journal*, Oct. 6, 1944.)

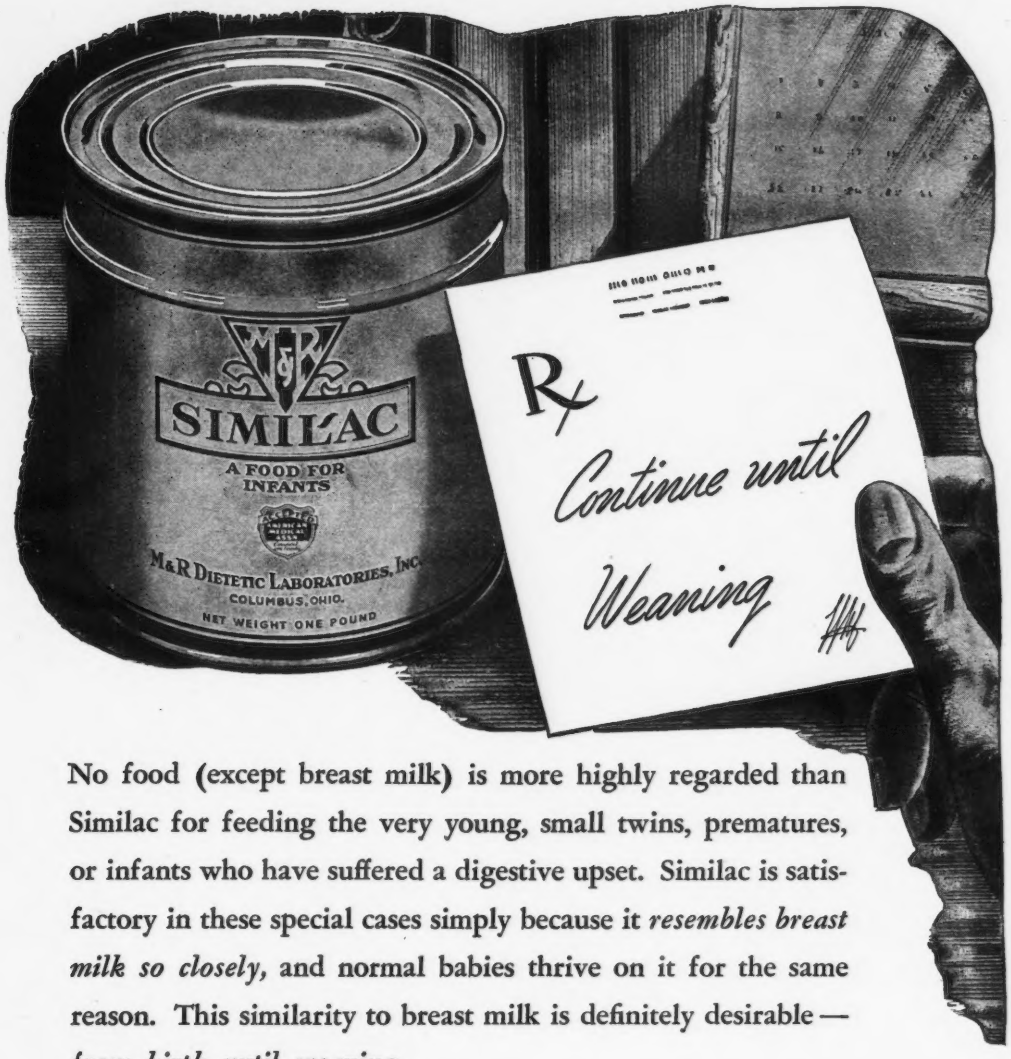
"Dr. Charles Bacon Boudwin, 64, 8656 East Fourteenth Street, Oakland, and his nurse, Mrs. Ella Berry, 41, today faced prison sentences of two to five years after an Oakland superior court jury yesterday found them guilty of performing an abortion on Mrs. Mildred Hatton of 6425 Essex Street a year ago. Boudwin's license to practice medicine has been withdrawn." (San Francisco *Bulletin*, October 14, 1944.)

"A Coroner's jury in Santa Monica yesterday found that Mrs. Frances Drapier, 33, of 1228 Lincoln Blvd., Santa Monica, died last Saturday as a result of an illegal operation, but the jury did not name any person responsible for the death. Following the inquest, Deputy District Attorney Kenneth Lynch said there was insufficient evidence to file a complaint against Mae Wilson, 53-year-old osteopath, who was arrested Tuesday on suspicion of murder in connection with Mrs. Drapier's death. She was released at that time on $5,000 bail." (Los Angeles *Times*, Oct. 27, 1944.)

"Charged with two violations of the state health and safety code, Dr. Milton F. Novotny, Long Beach physician, yesterday was acquitted in Los Angeles superior

(Continued in Back Advertising Section, on Page 40)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



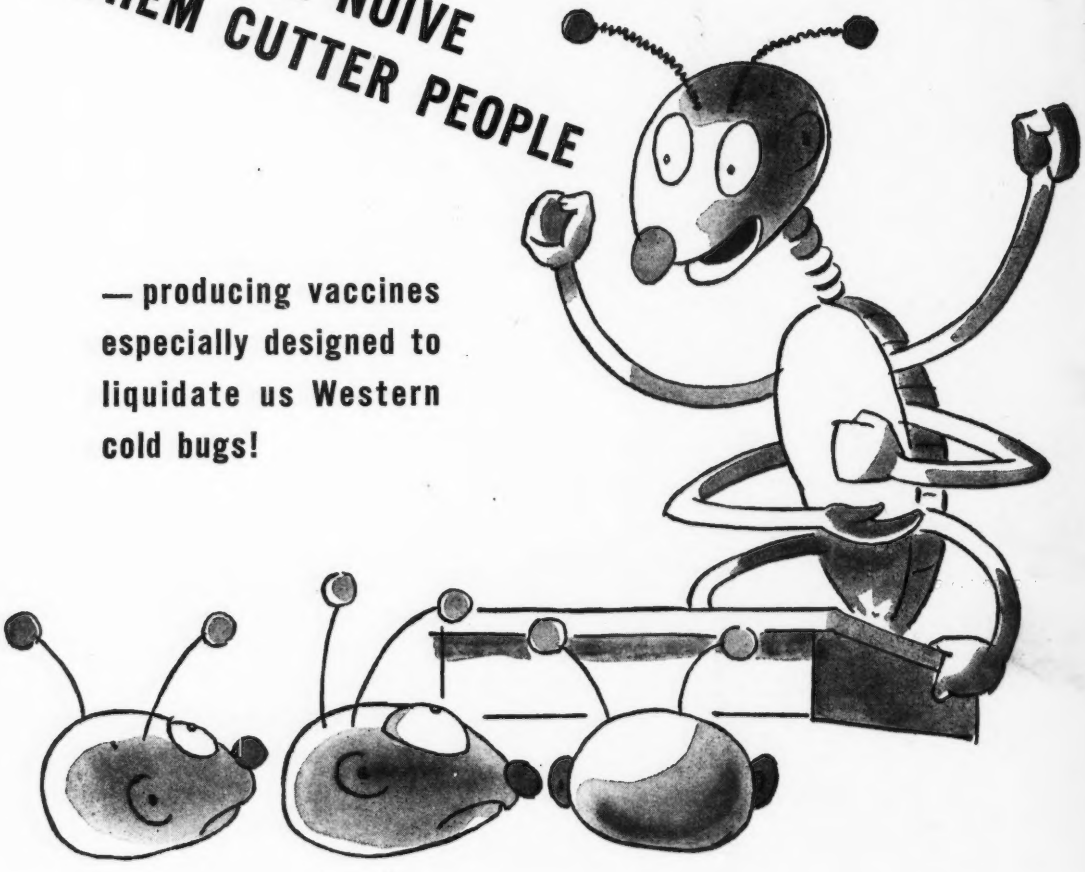
No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

SIMILAC } SIMILAR TO BREAST MILK

IMAGINE THE NOIVE OF THEM CUTTER PEOPLE



— producing vaccines especially designed to liquidate us Western cold bugs!

Cold bugs may well be alarmed—now that Western physicians know the big advantage in using Cutter Cold Vaccines!

All three vaccines are prepared from constantly changing, picked strains, obtained from Western sources—strains that your patients are most likely to contact. Three vaccines to suit any situation:

M. V. R. I. for injection

You'll want to start a series of M. V. R. I. shots with those patients who suffer from repeated colds, or from persistent symptoms. Such a series is usually instituted before the onset of the "cold season," but may be started whenever frequent respiratory infections are a problem.

M-V Nasal for Nasal Spray Immunization

Raises the titer of the circulating antibodies and greatly increases the antibody content of the nasal mucosa —the first line of defense. M-V Nasal is effective alone, or as a "booster" course following M. V. R. I.

M-V Oral, the Western-Strain Oral Vaccine

M-V Oral is not only produced from picked strains from Western cultures, it is specially cultured to be high in heterophile antigens—the ideal oral vaccine for Western use.

Save yourself time this winter by protecting your patients with Cutter Cold Vaccines.

CUTTER LABORATORIES, BERKELEY, CALIFORNIA

CUTTER

Fine Biologicals and Pharmaceutical Specialties